Alberta Health
Services

Alberta Health Services
Annual Report

April 1, 2009 – March 31, 2010

July 20, 2010

Alberta Health
Services

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For more information about any of the programs or services,
Please visit www.albertahealthservices.ca
Or call Health Link at 1-866-408-LINK

Letter of Accountability

We have the honor to present the annual report for Alberta Health Services for the fiscal year ended March 31, 2010.

This annual report was prepared under the Board's direction, in accordance with the *Government Accountability Act*, *Regional Health Authorities Act* and directions provided by the Minister of Health and Wellness. All material economic and fiscal implications known as of June 30, 2010 have been considered in preparing the Annual Report.

Respectfully submitted on behalf of Alberta Health Services Board,

"Original Signed by"

Ken Hughes
Chair, Alberta Health Services Board

Welcome to the 2009 - 2010 Annual Report

The 12 months summarized in this document represent Alberta Health Services' first year of operations. It has been a time of profound challenge in health care. Yet, in the face of many pressures, Alberta Health Services (AHS) and its collaborative partners have achieved many milestones and accomplishments, building momentum that will improve the delivery of health care in the months and years ahead.

The ensuing pages tell the stories of some of these achievements:

- Improving health. The Baby Steps campaign highlighted the experiences of five pregnant women from central Alberta who used available resources and supports — as well as their own willpower — to conquer the smoking habit. "Reducing smoking rates among pregnant women is vital to meeting the Alberta Tobacco Reduction Strategy (ATRS) goals for 2012," said Ken Hughes, Alberta Health Services Board Chair. "By reaching out to pregnant smokers, we have the opportunity to improve the health of two or more people. The baby steps campaign is about motivating women to take the small steps necessary to become smoke-free."
- Improving access. At Alberta Children's Hospital in Calgary, many young patients waiting in the emergency department are seeing doctors much sooner at a new 'flow bed' assessment area. About 60 per cent of patients coming to the hospital's emergency department are not seriously ill but do have ailments or injuries that require consultation with a physician. Without flow beds these children and their families would have experienced longer waits. Instead of spending time in emergency waiting rooms, they're now being transferred to the flow bed area, located just inside the emergency department, and receiving prompt consultation with a physician. This is one of a series of coordinated initiatives designed to improve access to medical services for Albertans throughout the province.
- Sharing expertise. At the height of the H1N1 Pandemic, Alberta's intensive care units were connected like never before. Telehealth (videoconference) equipment was redeployed in or near 18 ICUs in October 2009, allowing critical care teams throughout the province to consult each other, virtually face-to-face, at any time during the pandemic. The sharing of expertise allowed AHS to better care for critically ill patients in their communities.

These stories, and others profiled in this Annual Report, are just a small sampling of the achievements of AHS in 2009-2010. More stories are being shared through the media, on the AHS websites and in the inaugural AHS Yearbook for staff. (Key results are located in the Performance Measures and Financial Overview.)

Every day in health care, we are privileged to witness and take part in amazing stories like these – stories that embody a spirit of innovation, collaboration and caring for the community that will benefit Albertans, Canadians and the global community.

The opportunities awaiting us are unlimited.

Improving Health

Moms-to-be clear the air

CENTRAL ZONE -- Sometimes quitters can be winners. In central Alberta, where the smoking rate among pregnant women is about nine percent higher than the provincial average, a 2009 pilot project encouraged moms-to-be in the area to butt out — for the baby, for themselves, for good.

The five-week Baby Steps campaign highlighted the experiences of five pregnant women from central Alberta who used available resources and supports — as well as their own willpower — to conquer the smoking habit.

These stories were shared through media stories, in video vignettes shown in health-care facilities on closed-circuit television screens, and on posters and tip cards placed in strategic locations around central Alberta.

"Breaking a tobacco addiction is difficult. We wanted to show that many people have done it and there's support for those who want to quit," says Barb Olsen, Director of Public Health, Health Promotion and Prevention in the area.

The campaign also encouraged pregnant smokers to call Alberta Health Services' toll-free Smokers Helpline (1-866-332-2322) to receive confidential support.

"Smokers Helpline counsellors work with individuals, help them create a plan and then can do follow-up for up to 12 months from the quit date," says Olsen.

"The counsellors can connect people to community resources as well, so they're not on their own."

Studies show smoking during pregnancy poses serious risks for the woman and fetus. It has been shown to increase risks of complications in pregnancy and cause serious adverse fetal outcomes, including spontaneous abortions, premature births and low birth weights.

Marino Francispillai, Tobacco Control Program Leader, acknowledges the struggle to quit smoking is a difficult one, especially when the added stigma of being a pregnant smoker prevents people from seeking help.

The Baby Steps campaign is designed to break down that stigma.

> "Breaking a tobacco addiction is difficult. We wanted to show that many people have done it.'"

"It is important women know they are not alone and there are resources available to them," Francispillai says.

The five campaign spokeswomen — who hail from Red Deer, Lacombe, Wetaskiwin and Hobbema — were chosen from a group of more than 20 who auditioned to become the faces for the initiative.

Other Population Health Accomplishments

- **Colorectal Cancer Screening:** Wait times for non-urgent colonoscopies have been cut in half over a one-year period thanks to additional appointment times and process improvements at a Fort McMurray hospital. Patients at Northern Lights Regional Health Centre now wait an average of 20 days between a referral for a non-urgent colonoscopy and the procedure, down from 50 days one year ago – a 60% improvement.
- **Breast Cancer Screening:** Time and travel can make regular breast cancer screenings difficult to schedule, especially for women in remote areas of the province. To improve access, two digital mammography mobile units will visit about 100 communities this year and serve about 24,000 women. "For women in rural communities, particularly those who do not have easy access to mammography facilities, (the units) give them the ability to get the same service as women in larger centres without having to travel," says Joan Hauber, manager of the Screen Test mobile units for Alberta Health Services.
- **Wellness through Exercise:** Patients with kidney failure remove significantly more waste and toxins from their blood – and improving their overall wellness – when they pedal a stationary bike during hemodialysis. The Southern Alberta Renal Program offers exercise during hemodialysis to its patients at three locations: Calgary's Sheldon M. Chumir Health Centre and the South Calgary Health Centre, and the Lethbridge Dialysis Unit. More effective hemodialysis and regular exercise have made a big difference in Ralph Bosomworth's life. "My legs are stronger, I can breathe better and my legs aren't as stiff. It makes a big difference in the way I feel," says the 87-year-old Calgarian.
- **Healthy Eating:** Bonnie Middleton has a basket in the corner of her room where she can toss all the clothes that no longer fit. Middleton has been taking part in the Weight Loss for Life — Eat, Move & Live Well program created by AHS registered dietitians in Grande Prairie. "As the weight goes down, it builds my confidence up," says Middleton, who lost 23 pounds in six months. Education sessions are informal and allow participants to ask specific questions, participate in group discussions and access the information provided by the dietitians and other health care professionals. Similar obesity-prevention programs exist throughout the province.
- **Physical Activity:** In 2009, over the course of six months, 67-year-old Everett Blain logged enough steps to have walked from his home in Carstairs, north of Calgary, to Vancouver. The resident of Chinook Winds Lodge, a long-term care facility in Carstairs, notched 899.95 km in the Walk for the Health Of It, a partnership project between the Town of Carstairs and Alberta Health Services' Community Stroke Prevention project. It's helping Carstairs residents stay in shape. "Everett just makes walking part of his everyday life," says Teree Hokanson, Rural Health Promotion Strategist for Alberta Health Services. "We thought that tied in really well with the message we want to give to people. They don't have to drive. You can walk. We want to encourage those simple changes that really are sustainable."

Improving Seniors Care

Program helps seniors get back on their feet

Grace Foster is home again, sooner than she expected.

The 77-year-old had surgery on her fractured right hip last month. After two weeks in an Edmonton orthopedic rehabilitation program, she returned to her home in Beaumont.

"I was surprised when the physiotherapist started working with me as soon as I arrived," says Foster of her time at CapitalCare Grandview, a continuing care facility that has run the orthopedic rehabilitation program since October 2008.

"It was painful but they helped me and encouraged me to do the exercises. If I had problems, they found solutions."

Three years ago, when she fractured her left hip, she was in the hospital for 21 days.

"This time, I had a more severe break and now I'm going home after only 14 days and I feel more ready," Foster says.

CapitalCare, a wholly owned subsidiary of Alberta Health Services, runs the program on a 13-bed unit at its south Edmonton facility. The program aims to get adults recovering from orthopedic surgery or bone injury home safely—and sooner.

Since the program began, patients have, on average, returned home eight days sooner.

Most patients are referred from Misericordia Community Hospital, the Royal Alexandra Hospital and the University of Alberta Hospital. Their average age is 82.

Hip fractures in the elderly can be crippling and debilitating. For many seniors, these injuries are the beginning of a serious decline in health and can lead to long-term care. Rehabilitation helps more hip-fracture patients resume their normal lives, safe and healthy in their homes.

“There is a perception that, if you break your hip, you’re never going home again,” says unit manager Louise Haley. “What this program is saying is these patients are priority candidates for rehabilitation with the goal of returning home, with appropriate support.”

> “These patients are priority candidates for rehabilitation with the goal of returning home, with appropriate support.”

Rehabilitation is part of all daily activities, from getting up in the morning to eating meals in the dining room. Patients have two physiotherapy sessions a day to help them regain strength and endurance, and they have lessons using mobility aids (such as canes or walkers) so they can get around at home.

Once patients are stabilized, the goal is to get them back to doing the things they did before their fractures, Haley says.

“The staff here has a background in continuing care and understands what it takes to support and help seniors regain their sense of independence.”

For Foster, that means being able to walk her three dogs, including an English bulldog.

“The program has taught me how to follow my precautions, how to prevent more falls and how to do my exercises,” says Foster. “I can go home and enjoy my life, and I'm almost pain free.”

The program has served almost 450 patients to date. More than 1,100 people in the Edmonton area had hip fractures in the one-year period between March 31, 2008, and April 1, 2009.

The rehabilitation program is one of many Alberta Health Services initiatives designed to improve access and outcomes for patients needing orthopedic services.

Other Seniors Health Accomplishments

- **Falls Prevention:** Keeping seniors on their feet and out of the hospital is the goal of collaboration between the Falls Prevention and Home Care programs in Calgary. The joint project is significantly reducing the number of repeated falls and falls-related visits to emergency departments among a select population of more than 350 Home Care clients, according to recent data. The number of repeated falls decreased by 64% and the number of falls-related emergency visits by 79% for those clients who underwent a comprehensive fall risk assessment and intervention by a multi-disciplinary fall prevention team. This translates into fewer seniors having their independence and quality of life diminished by a preventable injury.
- **Managing medications** is one of the challenges facing seniors living at home. Elderly patients are often prescribed multiple medications, which can require several doses throughout the day. This can be confusing for some and potentially dangerous if medications are mixed up, missed or taken too frequently. At adult day programs in Calgary and Edmonton, every aspect of a senior’s health is taken into consideration, including management of medical and pharmaceutical care. “They have simplified my life,” George Whitehead, 70, says of the staff who operate Calgary’s Comprehensive Community Care program. “Now there’s no doubt about what I should be taking and when I should be taking them.”
- **Aggression Management related to Pain:** Camille Poulin would see it often when she was working in continuing care: dementia patients who become aggressive for no apparent reason. Poulin, a coordinator of community care based in Westlock, says she suspected, in some patients with cognitive impairment, the aggression was linked to pain. She conducted a four-month review of existing research and found it supported the existence of a relationship between pain and aggression in late-stage dementia. These individuals were unable to articulate their needs to care providers or family members and aggression was their only response. Thanks to her findings, AHS in the Jasper to Cold Lake area has adopted an aggression policy that includes assessing clients for pain as part of their overall aggression management.

Decreasing Wait Times

Sick children see physicians sooner

For patients and families, a trip to the emergency department with a child can be a stressful experience. Add a lengthy wait and the experience can be overwhelming.

With patients and families in mind, staff and physicians at Alberta Children's Hospital (ACH) streamlined the triage process so children would see a doctor in a much shorter time.

During typical peak times in the past year, more than 200 children a day visited ACH's emergency department, waiting as long as eight hours.

"We have very efficient processes for patients who are very acutely ill and for those with minor illnesses and injuries like lacerations or broken bones, but we were finding that the patients who come in with middle acuity illnesses were having the longest wait times," says Dr. David Chaulk, deputy chief of ACH Emergency.

The department assembled a team to analyze how patients move through the department.

They quickly found about 60% of patients requiring care fell into the middle acuity category. Their problem was how to sort the patients to find out who really needs to stay and who can go home without further care. The solution: to use "flow" beds to deal with high volumes of patients.

The flow beds provide a transitional triage area where physicians are able to quickly assess patients and determine their need for further treatment.

Flow beds, the team found, significantly reduce wait times. The second wave of Pandemic 2009 (H1N1) provided the real test.

"During the busiest point of the H1N1 second wave, we were seeing about 315 patients each day, but on average, the wait time was less than four hours. It was so impressive to see the staff handle these volumes so efficiently," Chaulk says.

"Because we have taken the time to sort out patients' needs right from the start, there are beds available for sick children. That makes a huge difference."

"It gets those who need to be seen in and treated faster"

With the introduction of flow beds, patients are spending less time waiting in beds that could be used for sicker patients. This also frees up nurses to tend to those with greater needs.

Rod Iwanow, the manager of ACH Emergency, says this method of seeing patients is unique.

"We have combined the concepts of waiting room care and physician liaisons at triage, which are used in other emergency departments across Canada. Neither of those fit our model, so we needed to find a hybrid system that would work here," he says.

"We spend a bit longer assessing the patients to determine who should be seen in the flow beds, but the result is that those who do end up transitioning into our department beds are those requiring more care.

"It gets those who need to be seen in, and treated faster."

Other Access Accomplishments

- **Medical Assessment Units:** Wait time doesn't need to be wasted time. Patients awaiting admission to an inpatient ward at Calgary's Rockyview General Hospital are being transferred out of the emergency department and into a short-term medical assessment unit, where physicians and nurses initiate consultations, treatment and diagnostics. Patients typically stay in the medical assessment unit between 24 and 48 hours. The unit frees up treatment space in the crowded emergency department and reduces the amount of time our patients wait to begin treatment.
- **Emergency Department Reduces Wait Times:** Over the past two years, a series of coordinated measures implemented by staff at Fort McMurray's Northern Lights Regional Health Centre has eased system pressures, reduced emergency department length of stay and ensured visitors see physicians and nurses sooner. According to survey results from the Health Quality Council of Alberta's Patient Experience Report, the number of patients waiting more than 15 minutes to have their condition assessed by a triage nurse has reduced by 30%, and the number of patients waiting more than two hours to see a physician has reduced by 15%.
- **Coordinated Cardiac Care:** Every year in Alberta, about 2,500 people have a heart attack, while 10,000 are diagnosed with heart failure, a condition that exists when the heart is unable to efficiently pump blood. The Alberta Cardiac Access Collaborative (ACAC) is coordinating and improving the care these and other cardiac patients receive. Over the past two years, new clinics opened in Camrose, Wainwright, Grande Prairie, Fort McMurray and Medicine Hat, while existing clinics in Lethbridge, Red Deer, Calgary and Edmonton were enhanced. "We wanted to fill in any gaps in this care process to make sure no one fell through the cracks," says Deb Gordon, senior vice-president, Major Tertiary Hospitals for Alberta Health Services.
- **Prostate Cancer Treatment:** A new high-tech robot in a Calgary hospital is now helping to treat men with prostate cancer. The first Calgary prostate procedure using the da Vinci Robot Si with enhanced high-definition 3D vision was performed in late February. Every year, hundreds of men in the Calgary area require a laparoscopic radical prostatectomy, a minimally invasive surgery to remove the prostate gland and surrounding tissue. The new robot will allow more surgeons to perform the procedure.
- **Reducing Medication Errors:** Reading the medication labels was difficult. Fixing them was easy. Following a recent provincial study, the medication labels used by the province's cancer centres are now more legible–and not just for sake of aesthetics. About 45% to 50% of all medication errors reported are related to product labeling, packaging and nomenclature. About 25 nursing and pharmacy staff analyzed existing labels and identified confusing or problematic elements. They also suggested changes to the labels they felt would better help health-care professionals locate and use information

Improving Primary Care Access

Integration of Addiction & Mental Health Services

An Alberta Health Services program offers new hope for individuals with both a severe mental illness and substance abuse issue.

The Centennial Centre for Mental Health and Brain Injury in Ponoka opened its 25-bed Concurrent Disorder Unit in April 2009. The unit represents progress in the integration of addiction and mental health services across the province.

"This unit will provide a vulnerable and under-served population with the accessible and specialized care they need," said Dianne MacGregor, program director for Centennial Centre.

"For these Albertans, there is now real hope for treatment and recovery."

According to a study by the Canadian Mental Health Association, 30% of adults with mental illness also have a substance abuse problem.

Yet, in the past, individuals with severe and persistent mental illness often had difficulty accessing and remaining engaged in addiction treatment, while people with an addiction issue were often excluded from receiving appropriate mental health services.

"With the integration of these services comes the opportunity to deliver them in a more coordinated way", says Craig Staniforth, a senior manager with Addiction and Mental Health.

"The Concurrent Disorder Unit is a tangible example of the opportunities for collaboration and co-operation within the areas of addiction and mental health," says Staniforth.

"Under this new structure in Alberta Health Services, the possibilities and potential to better serve Albertans in these two areas are boundless."

The unit will serve clients between 18 and 64 years of age, with an emphasis on treating Albertans between 18 and 24.

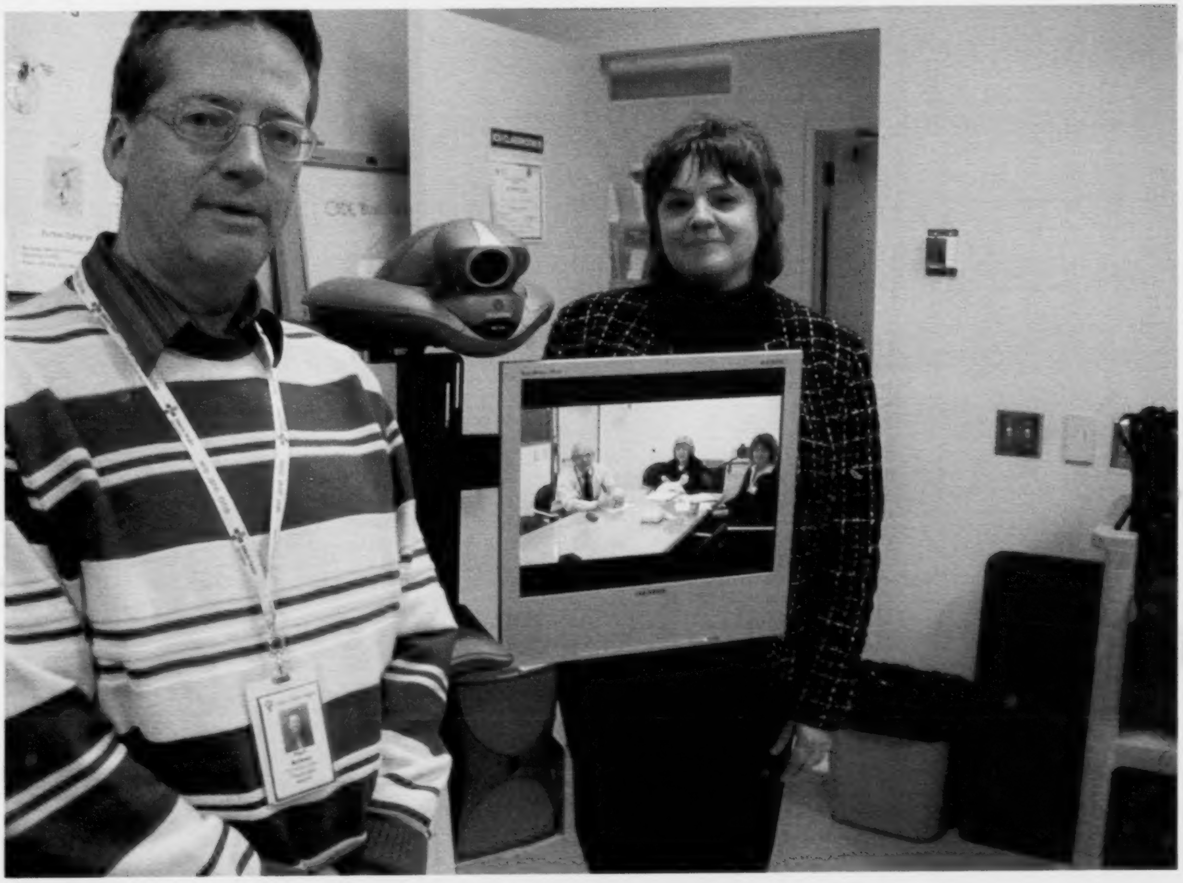
The philosophy of the program is solution-focused and client-centred.

As substance abuse-related problems and the more serious mental health symptoms are addressed, clients are assisted in accessing appropriate community options, including other AHS programs and services to ensure smooth transitions to and from the program.

Other Primary Care Accomplishments

- **Partnership with local physicians:** "Recent changes, including expanded colonoscopy clinics in Coaldale and improved partnerships with local physicians through the Chinook Primary Care Network (CPCN) based in south western Alberta, are making a difference for patients", says Bekki Tagg, clinical care coordinator at the Palliser Clinic. The primary care nurse says this means patients are getting quicker access to care. "Even (in 2008), people sometimes waited six months for a colonoscopy," she says. "The fact AHS, the Coaldale Clinic and our primary care network could coordinate it so people can get in faster; that's a success story in itself."
- **Chronic Disease Management:** Alberta Health Services is asking adults living with a chronic condition to participate in Healthy Living Canada, a free, online, self-management pilot project. Project lead Jennifer Painter says this is perfect for patients who may be socially or geographically isolated. "This program currently exists in a classroom setting," she explains, "but many people with chronic conditions are located in remote areas and cannot travel to where the class is offered." AHS wants to see if people can learn how to manage their chronic conditions through a web as effectively as they do in a classroom.
- **Primary Care Network in Edmonton:** Edmonton's new Northgate Health Centre, which opened in April 2010, offers convenient access for residents in a site that offers a combination of medical, professional and retail services. About 75,000 visits are expected to be made annually. The Centre is home to Edmonton North Primary Care Network, the Edmonton Hip and Knee clinic (relocated from College Plaza) and the North Edmonton Children's Centre Clinic.
- **Midwives provide Primary Care:** Women and their families now have another option when they decide to have children. Alberta Health Services, in association with Alberta Health and Wellness and the Alberta Association of Midwives (AAM), worked together to add midwifery to the publicly funded services in the province, effective April 1, 2009. Previously, Alberta couples who used a midwife paid out of pocket for these services. Patients will be entitled to choose the maternity care that is most appropriate, whether it be a midwife, general practitioner or referral to an obstetrician. Midwives provide primary care to women with low-risk pregnancies. The services include prenatal care, care during labor and birth, and post-partum care for mother and newborn for six weeks. In 2008, there were about 50,000 babies born in the province, about 500 of whom were delivered with the support of midwives.

Fit for the Future



Sharing Expertise

During the H1N1pandemic, Alberta's intensive care units (ICUs) were connected like never before.

Telehealth (videoconference) equipment was redeployed in or near 18 ICUs in October 2009, allowing critical care teams throughout the province to consult each other, virtually face-to-face, at any time during the H1N1 surge. This exchange of information and expertise allows smaller ICUs to manage many critically ill patients themselves, optimizing Alberta's critical care capacity.

"When we were planning for pandemic, we knew we would need to rely on each other because critical care capacity in the province was going to be stressed," says Caroline Hatcher, director of cardiac sciences, critical care and NICU at Foothills Medical Centre in Calgary. "Telehealth has enabled our ICUs to be successful in working together."

Each ICU in Edmonton and Calgary is paired with an ICU in one of five smaller urban centres: Red Deer, Fort McMurray, Grande Prairie, Lethbridge and Medicine Hat. Also linked are the Edmonton and Calgary teams dealing specifically with the most difficult H1N1 cases.

The telehealth equipment is augmented by PACS (picture archiving and communication system), which permits real-time sharing of medical images.

Dr. Noel Gibney, Medical Director of Critical Care for the Edmonton Zone and intensivist at the University of Alberta Hospital (UAH), says the technology plays an important role in the treatment of critically ill patients at his site and at its buddy site, Northern Lights Regional Health Centre (NLRHC) in Fort McMurray.

"It enables us to advise physicians there on the management of many cases that, otherwise, would have been transferred to Edmonton. When possible, it's good for critically ill patients to stay where they are, and it's good for the system, too," he says. "It also helps us identify early those patients who are becoming progressively unstable, so we can arrange to have them transferred to us while it is still relatively safe to do so."

"The UAH support is appreciated by staff at Fort McMurray", says Dale Marshall, the operational lead for critical care services at NLRHC. The hospital offers MRI, CT scans and invasive monitoring equipment and can care for patients with complicated health needs.

"But we're not a big tertiary care centre," Marshall says. "We do a great job but sometimes we can benefit from the expertise available elsewhere in the province. That's why the telehealth connection was vital. It gave staff here the support and confidence to care for these patients."

Having all provinces' ICU teams linked also allows rapid dissemination of pandemic information, adds Dr. Cheri Nijssen-Jordan, co-lead of pandemic clinical operations for Alberta Health Services.

Getting the technology to the right location in a timely manner was the biggest of several challenges, says Jason Kettle, provincial lead, telehealth and multimedia technical services.

"We don't throw a videoconference device in a room; there are a lot of factors that need to be considered to ensure patient safety and confidentiality," he says. Hatcher, Gibney and Marshall report their staff learned how to operate the system in less than 30 minutes.

Kettle is proud of the work and what it means for patients, families and Alberta Health Services as an organization. "It starts to move us toward truly being one," he says.

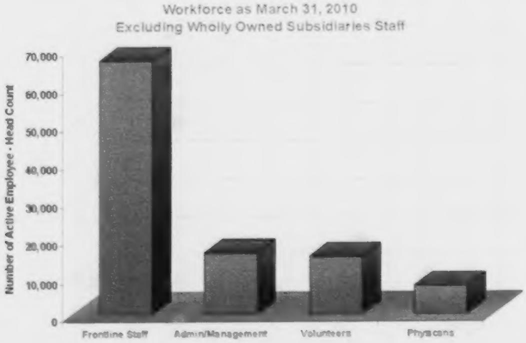
Adds Marshall: "Care should be consistent wherever you are in the province. This helps move us toward that goal."

Other Accomplishments

- **Emergency Preparedness:** When staff members visit sites across the province for professional and educational opportunities, they can be confident uniform emergency codes apply. The Emergency Preparedness Council, a provincial group with representation from each of the former health regions, worked to standardize the codes for use across Alberta Health Services. The standardization of codes is a first step in the integration of emergency response activities and lays the foundation for alignment of emergency response procedures and training programs for Alberta Health Services staff.
- **e-record System:** Alberta Children's Hospital (ACH) went live with Calgary's acute care e-record system in May 2009, becoming the fourth major hospital in the city to do so. Belinda Boleantu, Vice President of Clinical Transformation Services, says this is an example of AHS leadership in the use of health-care technology. "The roll-out of the acute e-record system in Calgary represents one of the largest implementations in North America and this technology is considered the most valuable IT tool for health care," says Boleantu. The e-record system electronically links patient information across Calgary's four acute hospitals, meaning each patient's health information is collected and stored in a single, electronic health record. With ACH on board, the system now makes more than 2.9 million individual patient e-records available to authorized health professionals as they deliver collaborative care.
- **e-Learning Module** is an educational tool that supports standardized learning on Alberta's Continuing Care Health Service Standards (CCHSS). The module, launched in March 2009 on the Continuing Care Desktop, trains staff to understand how the standards apply to the care they provide each day; identify their roles and responsibilities related to the standards; and recognize how they can contribute to and improve quality of care.
  Change may be constant, but true transformation is rare. The Workplace Transformation initiative is an opportunity for Alberta Health Services to completely redesign, for the first time in a generation, how we deliver health care, services and programs in the province. This initiative will involve the entire AHS workforce. Teams will develop collaborative, interdisciplinary and sustainable approaches to providing consistent, engaging care and services to patients. Current plans call for Workplace Transformation to begin in Spring 2010 at the University of Alberta Hospital (UAH) in Edmonton and the Peter Lougheed Centre in Calgary later in the year. As the project evolves, the initiative will roll out to all health care areas across the province.

Who We Are

We are the 117,000 skilled and dedicated health professionals, support staff, volunteers and physicians who promote wellness and provide care every day to 3.7 million Albertans, as well many residents of southwestern Saskatchewan, southeastern British Columbia and the Northwest Territories. This includes approximately 82,500 direct AHS employees and approximately 12,000 staff working in AHS wholly owned subsidiaries such as Carewest, Capital Care Group and Calgary Laboratory Services (excludes Covenant Health staff), 15,000 volunteers and 7,400 physicians (this figure is the total physician count for Alberta both employed and independent physicians). Students from Alberta's universities and colleges, as well as from universities and colleges outside of Alberta, receive clinical education in AHS facilities.



Programs and services are offered at 400 facilities throughout the province, including hospitals, clinics, continuing care facilities, mental health facilities and community health sites. The province also has an extensive network of community-based services designed to assist Albertans maintain and/or improve health status. Service is available by phone through the province's Health Link service.

Alberta Health Services is required to prepare and submit to the Minister of Health and Wellness an annual report in compliance with the *Government Accountability Act* and the *Regional Health Authorities Act*. The annual report is provided to the Minister in the form and manner prescribed and is a key public accountability document that reports how Alberta Health Services discharged its legislated responsibilities and any other responsibilities delegated to it by the Minister. The Minister tables the annual report in the Legislative Assembly.

Alberta Health Services is expected to work within its approved budget and is responsible to:

1. conduct needs assessments,
2. support wellness,
3. provide information to Albertans that allows them to make informed decisions,
4. solicit community input and dialogue,
5. maintain service planning for a full continuum of health services,
6. ensure reasonable access to services,
7. allocate and manage resources,
8. monitor, report on and evaluate services and regional system performance,
9. consult with other sectors, and
10. maintain a patient concerns resolution process.

All programs and facilities, whether they are owned and operated by AHS, non-profit organizations or private groups, are operated in compliance with specific pieces of program legislation, including:

- the *Hospitals Act* respecting the operation of hospital programs;
- the *Health Care Protection Act* respecting the operation of non-hospital surgical facilities;
- the *Nursing Homes Act* respecting the operation of nursing home programs;
- the *Mental Health Act* respecting the admission, detention, administration and treatment and control of mental health patients;
- the *Public Health Act* respecting home care and the prevention and control of communicable diseases and health hazards;
- the *Health Information Act* respecting the collection, use, disclosure, management and protection of the health information created in the care process.

Mission

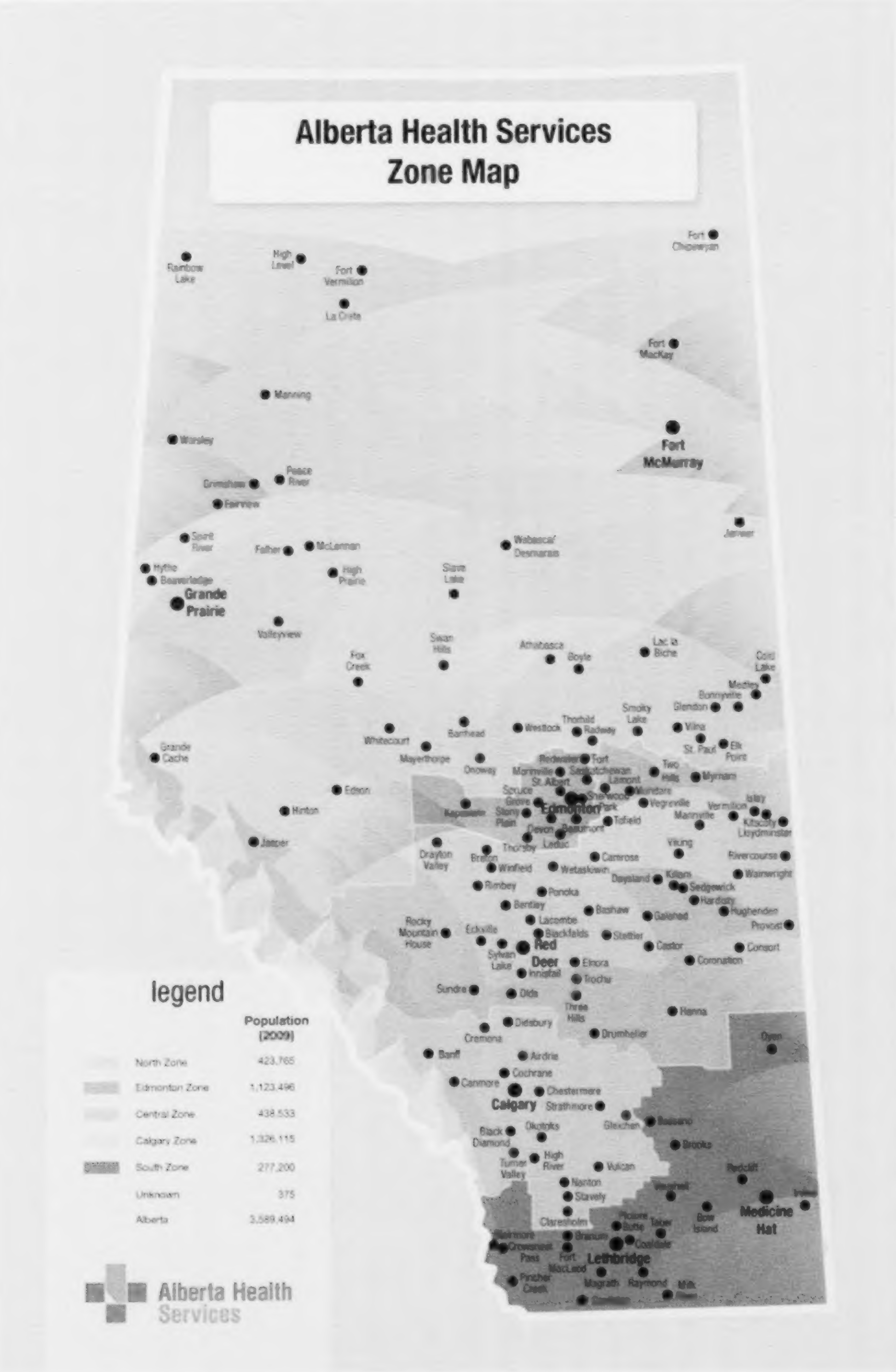
To provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

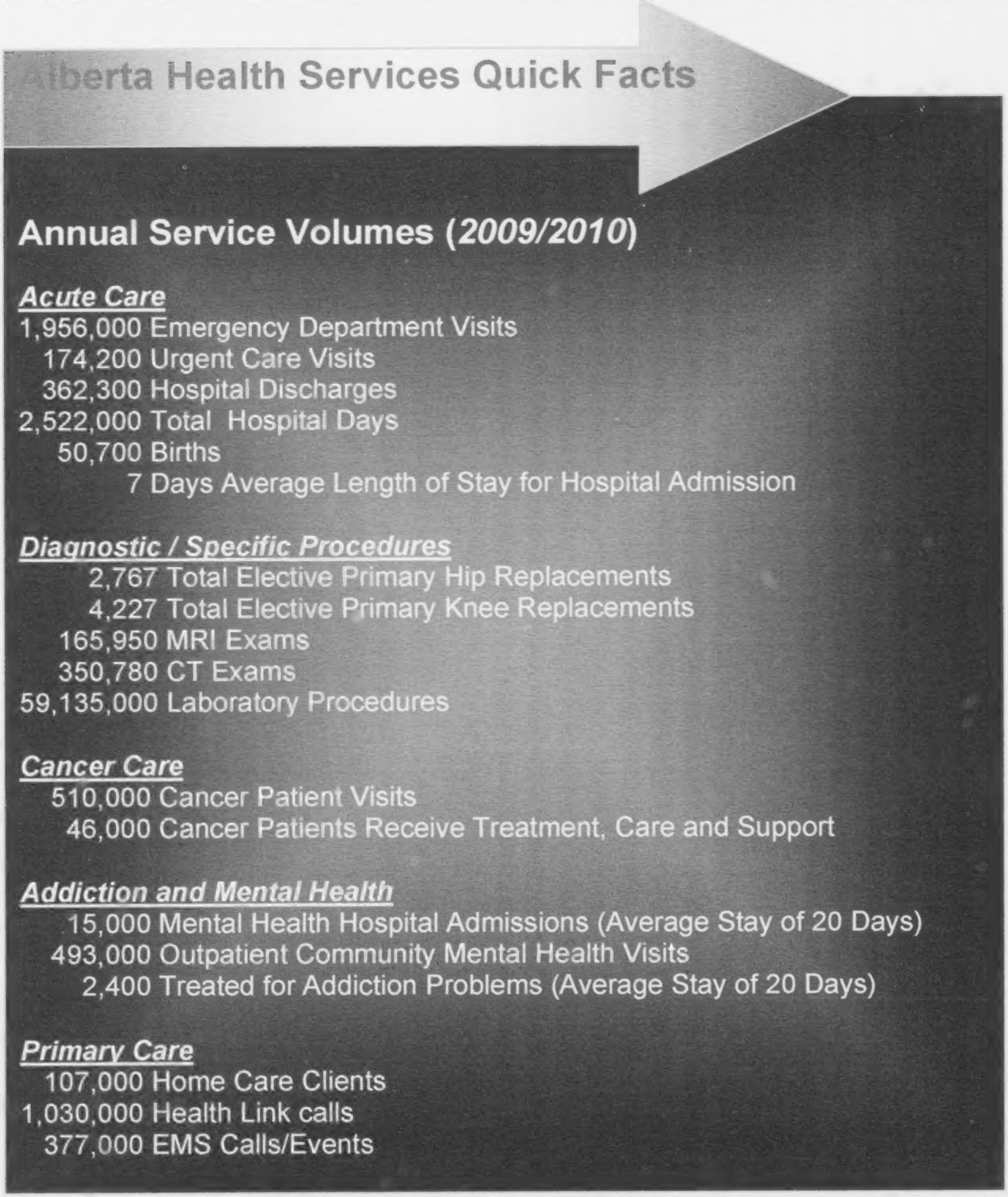
Goals

Quality: health care services are safe, effective and patient-focused

Access: appropriate health care services are available

Sustainability: health care services are provided within available resources both now and into the future


Alberta Health Services Zone Map
legend
Population (2009)
North Zone 423,765
Edmonton Zone 1,123,496
Central Zone 438,533
Calgary Zone 1,326,115
South Zone 277,200
Unknown 375
Alberta 3,589,494
Alberta Health Services
Fort Chipewyan
Rainbow Lake
High Level
Fort Vermilion
La Crete
Fort MacKay
Manning
Worsley
Fort McMurray
Grimshaw
Peace River
Fairview
Spirit River
Falher
McLennan
Wabasca/Desmarais
Hythe
Beaverlodge
High Prairie
Slave Lake
Grande Prairie
Valleyview
Fox Creek
Swan Hills
Athabasca
Boyle
Lac la Biche
Cold Lake
Grande Cache
Whitecourt
Barrhead
Westlock
Thorhild
Radway
Smoky Lake
Glendon
Bonnyville
Vilna
St. Paul
Elk Point
Mayerthorpe
Onoway
Redwater
Fort Saskatchewan
Morinville
St. Albert
Lamont
Two Hills
Myrnam
Edson
Hinton
Spruce Grove
Stony Plain
Edmonton
Sherwood Park
Mundare
Vegreville
Vermilion
Islay
Kitscoty
Lloydminster
Mannville
Tofield
Devon
Beaumont
Leduc
Thorsby
Jasper
Drayton Valley
Breton
Winfield
Wetaskiwin
Camrose
Viking
Rivercourse
Daysland
Killam
Wainwright
Sedgewick
Hardisty
Rimbey
Ponoka
Bentley
Lacombe
Bashaw
Galahad
Hughenden
Provost
Rocky Mountain House
Eckville
Blackfalds
Stettler
Castor
Consort
Sylvan Lake
Red Deer
Innisfail
Elnora
Trochu
Coronation
Sundre
Olds
Three Hills
Hanna
Didsbury
Cremona
Drumheller
Oyen
Banff
Airdrie
Cochrane
Canmore
Chestermere
Calgary
Strathmore
Gleichen
Bassano
Black Diamond
Okotoks
Brooks
Turner Valley
High River
Vulcan
Redcliff
Nanton
Stavely
Vauxhall
Medicine Hat
Claresholm
Picture Butte
Taber
Bow Island
Blairmore
Crowsnest Pass
Granum
Coaldale
Fort MacLeod
Lethbridge
Pincher Creek
Magrath
Raymond
Milk River
Cardston



Alberta Health Services Quick Facts

Annual Service Volumes (*2009/2010*)

Acute Care

1,956,000 Emergency Department Visits
174,200 Urgent Care Visits
362,300 Hospital Discharges
2,522,000 Total Hospital Days
50,700 Births
7 Days Average Length of Stay for Hospital Admission

Diagnostic / Specific Procedures

2,767 Total Elective Primary Hip Replacements
4,227 Total Elective Primary Knee Replacements
165,950 MRI Exams
350,780 CT Exams
59,135,000 Laboratory Procedures

Cancer Care

510,000 Cancer Patient Visits
46,000 Cancer Patients Receive Treatment, Care and Support

Addiction and Mental Health

15,000 Mental Health Hospital Admissions (Average Stay of 20 Days)
493,000 Outpatient Community Mental Health Visits
2,400 Treated for Addiction Problems (Average Stay of 20 Days)

Primary Care

107,000 Home Care Clients
1,030,000 Health Link calls
377,000 EMS Calls/Events

Bed Numbers

Reported Beds Staffed & In Operation Summary as of March 31st

Alberta Health Services Beds by Type

Number of Beds/Spaces	As of March 31, 2009	As of March 31, 2010	Difference	% Change
Psychiatric (stand alone facilities)	880	862	-18	-2%*
Acute Care				
Acute Care	6,263	6,328	65	1%
Acute Care Psychiatric	625	625	0	0%
Neonatal Intensive Care Unit	258	254	-4	-2%
Special Care Units (ICU, CCU, etc.)	359	361	2	1%
Palliative in Acute Care	97	97	0	0%
Subacute in Acute Care	117	137	20	17%
SUBTOTAL ACUTE CARE	**7,719**	**7,802**	**83**	**1%**
Continuing Care (Long Term Care and Supportive Living)	**19,176**	**19,557**	**381**	**2%**
Other				
Addiction Treatment	1,295	1,409	114	9%
Sub-acute (outside a hospital)	415	418	3	1%
Palliative and Hospice (outside a hospital)	160	162	2	1%
Community Mental Health Homes	430	450	20	5%
Community Support Beds	48	54	6	13%
Alberta Total	**30,123**	**30,714**	**591**	**2%**

Source: AHS Bed Survey as of March 31, 2010

** Decrease reflects shifting from inpatient to supportive living settings.*

There are 103 facilities (98 acute care hospitals and 5 standalone psychiatric facilities; this includes 65 acute care beds in the Lloydminster Hospital, Saskatchewan).

Board Governance

An enormous amount of work has gone into the creation of a single, province wide health care delivery organization since the announcement on May 15, 2008 of the plan to integrate 12 former health entities.

The transformation in progress challenges us to build on the innovation already occurring across the province, and to ensure good ideas and best practices from one area are successfully implemented in all others. We will be setting ambitious performance measures in our quest to build a health care system that will become the gold standard for public health care around the world.

During this exciting time of change we ask for the support of Albertans to ensure the health needs of those we serve are met as we work to create a patient-focused health care system that is accessible and sustainable for everyone.

Alberta Health Services Board:

Tasked with coordinating the delivery of health supports and services across the province, the AHS Board supports the Minister of Health and Wellness' mandate to improve access to care and to create a sustainable health system. This 15 member board reports directly to the Minister:

Ken Hughes (Chair)
Catherine Roozen (Vice Chair)
Jack Ady
Lori Andreachuk
Gord Bontje
Teri Lynn Bougie
Jim Clifford
Strater Crowfoot
Tony Franceschini
Linda Hohol
Andreas Laupacis
John Lehners
Irene Lewis
Don Sieben
Gord Winkel

Alberta Health Services Board Committees include: Audit and Finance Committee, Ethics and Quality Committee, Governance Committee, Health Advisory Committee, Human Resources Committee and Waiver Committee.

Health Advisory Councils

Albertans provide input on local health issues across the province with the establishment of Health Advisory Councils. In July 2009 it was announced that the 12 Health Advisory Councils replaced 59 Community Health Councils which operated under the former health regions. The Councils consist of 10 to 15 members, including a Chair and will each represent a different geographical area. All Council members will be appointed by the AHS Board. The mandate of the Councils is to provide feedback about what is working well in the health care system and areas in need of improvement. The Councils will engage residents and report on local perspectives of health care delivery in communities across the province.

Organizational Structure

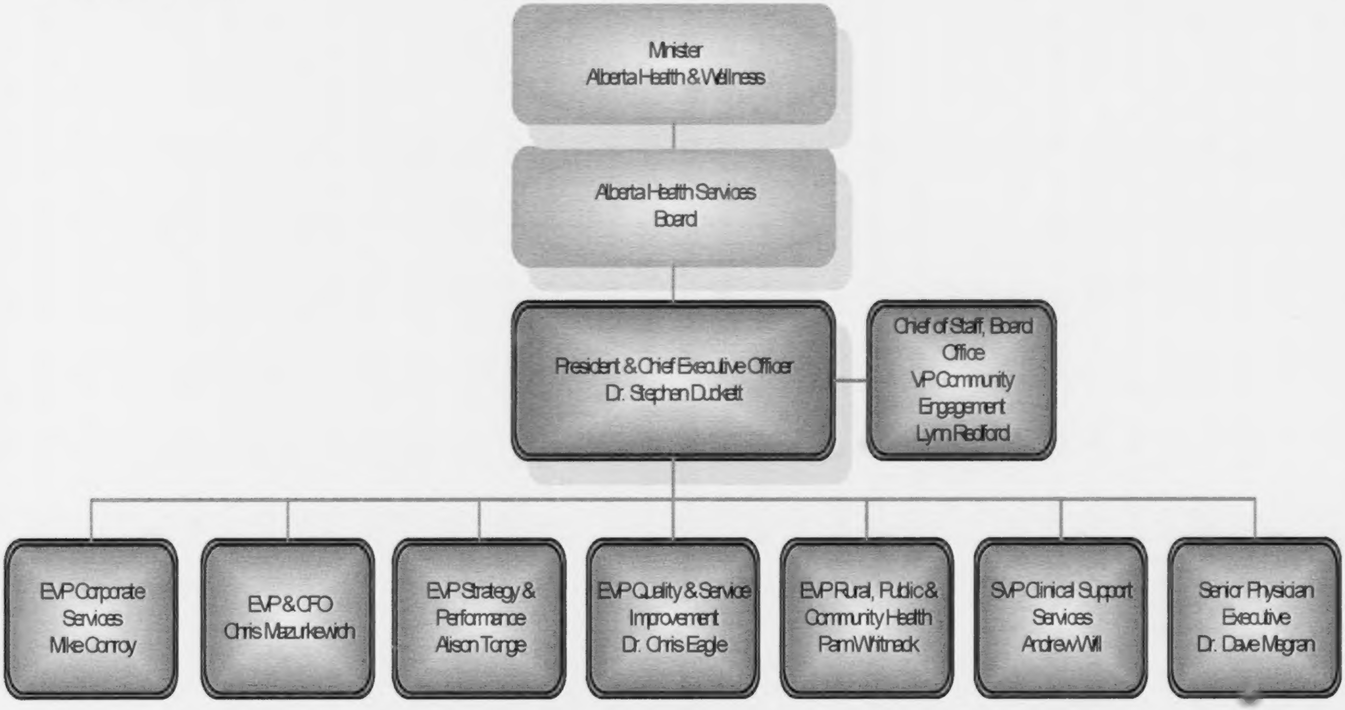
Effective June 1, 2009, everyone in the organization became accountable through a new organizational structure. The new structure was but one step in the creation of Alberta Health Services, and supports the following changes in the culture:

- Taking a provincial perspective on issues.
- Ensuring good ideas developed in one part of the province are shared across the province.
- To exemplify every day, the four AHS values of respect, accountability, transparency and engagement.

Creating and embedding this culture will be a critical task for all leaders and staff in the organization. Our organizational structure is arranged into the following areas:

- Quality and Service Improvement
- Strategy and Performance
- Rural, Public and Community Health
- Finance
- Corporate Services
- Senior Physician Executive
- Clinical Support Services

Each area is led by a member of the executive team, all reporting directly to the President and Chief Executive Officer.


Minister
Alberta Health & Wellness
Alberta Health Services
Board
President & Chief Executive Officer
Dr. Stephen Duckett
Chief of Staff, Board Office
VP Community Engagement
Lynn Redford
EVP Corporate Services
Mike Conroy
EVP & CFO
Chris Mazurkewich
EVP Strategy & Performance
Alison Tonge
EVP Quality & Service Improvement
Dr. Chris Eagle
EVP Rural, Public & Community Health
Pam Whitnack
SVP Clinical Support Services
Andrew Will
Senior Physician Executive
Dr. Dave Megran

Strategic Initiatives, Accomplishments and Performance Results

Alberta Health Services is moving from strategy to action, with an emphasis on access and quality. Our goals are to reduce wait times, and to implement innovations that are making our province a national leader in health and wellness.

The 2009/2010 year was challenging from many perspectives. Much work continued to be required to build the foundation for operating as one health system and capitalize on the opportunities afforded through merging organizations. The Pandemic H1N1 also posed many challenges for AHS, as did budget uncertainty.

As outlined on the following pages, while much progress was made on improving on the areas of focus outlined in our Strategic Plan, only 50% of the targets were achieved. As evidenced in many of the performance measures related to access, we are currently behind schedule in improving access to care to the current system and changes are underway to make improvements. These system changes remain a high priority for the upcoming year. Some very positive steps have been recently initiated including the certainty of a 5-year funding agreement.

We have introduced innovations to reduce Emergency Department wait times. At the Rockyview General Hospital, Emergency Medical Technicians (EMTs) are teamed with registered nurses in a pilot that makes sure patients are assessed and treated more quickly, while getting ambulances back on the road as soon as possible. The pilot began in December, and will be evaluated in six months, but is already making a difference. Since these waiting room changes were introduced to the Foothills, Rockyview and Peter Lougheed centre, the Emergency Departments have recorded:

- shorter waits for physician assessment for urgent patients,
- fewer patients waiting to be seen,
- reductions in the average length of time people are in the Emergency Department from assessment to discharge or admission,
- and a reduction in the number of patients who leave without being seen by a physician.

An $8 million dollar six-month blitz to bring surgical wait lists down was announced earlier this year, adding some 2,300 more surgeries across Alberta in six weeks alone, from mid-February to the end of March.

The Alberta Health Services Strategic Plan's key goal of sustainability necessarily consumed a great deal of energy during the past year. It was imperative that we streamline back-office processes, reduce unnecessary duplication and waste, and effectively leverage the buying power of a province-wide health system. Initiatives completed in 2009/2010 resulted in almost $500 million of savings relative to 2008/2009 and avoided costs previously planned. This reduced the rate of increase in expenditures from 12% in the prior year to 8% in 2009/2010.

1. Improving population health

Alberta's population is growing, rapidly aging and facing a significant burden of chronic disease. The costs for managing these diseases are increasing. Within Alberta there are specific populations that require targeted and customized approaches to meeting their health care needs. While it is important to think of Alberta as a whole it is also important to give special attention to diverse population needs with the aim to reduce inequities of outcomes.

By focusing on health promotion, disease prevention and wellness, we can enable Albertans to take better care of themselves. By focusing on improving both physical and mental health, we are decreasing the future demand for care and treatment, improving the quality of life for Albertans and enhancing the sustainability of our health system.

1. Improving population health

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
1.1 Burden of disease		
Pandemic HINI Flu Virus Response & Preparation	60% of population immunized. Provide access to H1N1 vaccine to residents. Develop AHS Pandemic H1N1 2009 Response Plan. Develop comprehensive communications plan with role of physicians in H1N1 Response.	Pandemic H1N1 (2009) posed many challenges for AHS, a young and evolving organization. However, there were many successes and highlights including: • High level of engagement and commitment of AHS staff and physicians in H1N1 efforts. • Minimal disruption of "normal" health care activities during the pandemic. • Excellent management of emergency, acute care and critical capacity during the pandemic. • Successful mobilization and redeployment of staff to meet the challenges. • Successful implementation of innovative strategies such as the "Influenza Assessment Centres". • Very high and unprecedented staff immunization rates. • Apparent blunting and shortening of the severity and duration of the pandemic likely related to public immunization and antiviral treatment strategies. H1N1 activity has virtually ceased in Alberta. However, H1N1 continues to circulate in select regions of the world including the southeastern United States. Two cases of H1N1 in Albertans returning from such areas were recently reported. It is estimated that one third of Albertans chose to be immunized against H1N1 during the recent vaccination campaign. This is below the rates achieved by some provinces (up to 50-60%) but similar to others including British Columbia, Manitoba, and Nova Scotia. Evaluation of the physician components of the Pandemic H1N1 plan (including communications) is complete. Results are being documented and recommendations for further work drafted for consideration by the Senior Physician Executive. *The 2009/2010 Major Initiatives were achieved but Performance Measure Targets were not achieved. Learnings from the H1N1 response will be incorporated into planning for the future.*

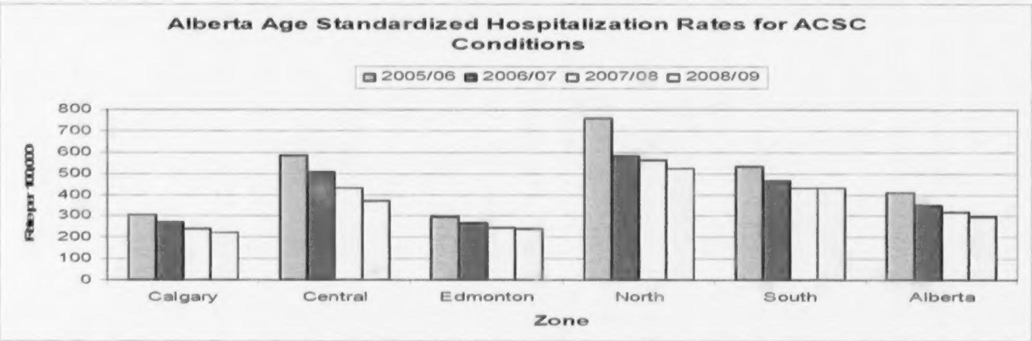
Pandemic (H1N1) 2009 Influenza Immunization (Oct. 26, 2009 – May 30, 2010)	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Total AHS
% Immunized	**34.1%**	**40.9%**	**23.9%**	**36.2%**	**28.6%**	**36.6%**

1. Improving population health

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
Strengthen awareness and availability of community-based services for people with chronic disease.	Develop organization-wide plan for chronic disease management that incorporates primary care networks. Develop decision support tools for providers that support evidence informed care. Develop strategy to renegotiate tripartite agreement which will strengthen chronic disease management. Develop pay for performance to strengthen chronic disease management.	The Provincial Chronic Disease Management Strategy was developed with extensive community and provider/physician consultation, and will incorporate primary care networks (PCNs). This followed a comprehensive analysis to identify recommendations for targeting priority chronic diseases. Key strategic partnerships have been established to advance work across portfolios, with Zones and with PCN's, and the Provincial Primary Care / Chronic Disease Management Leadership Committee was developed. A number of initiatives and working groups have been developed from the strategy for organization-wide Chronic Disease Management (CDM) planning including: • Team Based Complex Care Planning. • Provincial Self Management - Online Stanford Self Management workshops are up and running. • Professional Education. • Provincial Diverse Populations. • Provincial Screening Advisory. • Chronic Disease Registry. • Participation in Clinical Networks and involvement in pathway development. Primary Care physicians and/or staff and patients are represented along with many AHS partners in these working groups and collaborative relationships are being developed. Decision support tools for providers that support evidence informed care will be developed as part of this work. A plan has been developed for a Primary Health Care Strategy and Primary Care model under the overarching Transformational Improvement Program (TIP): "Building a Primary Care Foundation". The plan includes the development of strategies for funding, interprofessional teams, integration, and infrastructure to support the preferred Primary Care model. "Discussion Paper on Primary Care Models" was finalized and initial targeted consultation completed. Broad stakeholder consultation is underway, including Alberta Clinicians Council, AMA, Health Advisory Councils, and Primary Care Networks. *The 2009/2010 Major Initiatives were achieved.*

Performance Measure	FY 2008/2009	FY 2009/2010	2009/2010 Targets
		Est. Yearly rate based on last 3 Quarters	
Hospitalization rates for all ambulatory care sensitive conditions (chronic disease) per 100,000	297	294 (estimated annual based on the last 4 quarters - calendar year 2009)	285

Source: AHS



Alberta Age Standardized Hospitalization Rates for ACSC Conditions

1. Improving population health

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
Implement comprehensive health promotion strategies to reduce the burden of disease, injury and disability, and allow for better use of health system resources.	Develop province-wide, consistent approach to screening of disease (e.g. cancer, diabetes)	***Cancer Surveillance/Screening:*** Continued to implement evidence informed strategies and approaches to improve breast, cervical and colorectal cancer screening. Revised breast, cervical and colorectal cancer screening brochures and other educational resources for the general public and health care providers. Updated cancer screening program web pages. Developed Aboriginal breast, cervical and colorectal cancer screening educational resource kits. Reviewed the Screening Programs' Information Technology /Information Management requirements and developed a go forward strategy. Completed the digital mammography project and now *Screen Test* services have been fully converted to digital technology. In collaboration with Primary Care and Chronic Disease Management, planning is underway to develop a population-based, provincial approach for screening of chronic diseases. Report on Cancer Statistics in Alberta (2006) is available online; includes separate reports on overall cancer in Alberta, the top 10 cancer sites, and childhood cancer. Completed first draft of Trend Analysis Report and provided training to pan-Canadian representatives in Toronto. Received Cancer Projection Network contract from the Canadian Partnership Against Cancer; currently under review by AHS ***Healthy Development:*** ***Screening:*** *Newborn Metabolic Screening (NMS):* Collaborated with Alberta Health and Wellness and the Zones to: • Modify the Newborn Metabolic Screening database to ensure alignment with new AHS structure. The new version of the database was available to end users March 12, 2010. • Complete a retrospective audit of Newborn Metabolic Screening in the province (from sample draw to receipt of sample at the NMS lab). • Develop a province wide quality improvement initiative related to Newborn Metabolic Screening. ***Healthy Weights:*** Collaborated with the Alberta Perinatal Health Program to complete an online module for health professionals across the province on Pre-pregnancy/pregnancy Weight Gain. Successfully transitioned the Healthy Weights Initiative from former Regional Health Authorities to Health Promotion, Disease & Injury Prevention. Joint provincial work plan established; provincial budget developed. Contract extended with AHW to fund Health Promotion Coordinator positions to May 31, 2011. ***Chronic Disease Prevention:*** Established a Provincial Dental Public Health Officer position. Initiated a comprehensive review of Health Link's dental information. Managed H1N1 prevention, client and staff safety protocols in Dental Public Health Clinics. Online version of exercise program for seniors in assisted living sites ('Move and Mingle') was developed. Program was transferred to Senior's Health and 1.5 FTE was transferred to the Calgary Zone to support the program. ***Injury Prevention:*** Reports on various initiatives are being prepared, analyzed and evaluated, and committees established. *The 2009/2010 Major Initiatives were achieved.*

1. Improving population health

Performance Measure	2006*	2008*	Baseline 2007	FY 2008/2009**	FY 2009/ 2010	2009/2010 Targets
Self reported health status: % of Albertans reporting "excellent", "very good" or "good" health						
18 to 64 years	87.9%	88.4%	88.0%	91.9%	Data not available at time of report.	90.0%
65 years and over	86.2%	84.2%	84.0%	77.1%		85.0%

*Source: * HQCA*
*** CCHS (2008/2009 combined with 2007/2008 was received November 2009)*

1.2 Healthy communities

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
Strengthen prevention, preparation and response to public health risks. Increase education, support and propose new legislation to better assist Albertans to make healthy choices and protect their health. Target efforts to reduce rates of smoking, obesity, substance abuse, addictions and other factors that negatively impact health and well-being. Facilitate people to understand choices and take responsibility for their own health.	63% of seniors received influenza immunization Implement comprehensive plan for providing influenza vaccine across the province. Advocate for policy change on a minimum of 2 provincial policies (e.g. healthy eating and/or physical activity) that reduce injuries and/or chronic disease.	***Influenza Immunization:*** Approximately 34% of Albertans have been immunized for H1N1. Demand for the vaccine decreased sharply in the winter months and all mass clinics were discontinued by the end of the first week in February 2010. ***H1N1 Update:*** Deployment of H1N1 vaccine to Albertans, with the addition of new community partners. A summary surveillance report was produced in partnership with Alberta Health and Wellness. ***Chronic Disease Prevention:*** Developed strong internal and external partnerships to support and advance work that aligns with Primary Prevention - physical activity and nutrition. Committee established for developing the Provincial Built Environment Strategy led/chaired by Health Promotion, Disease & Injury Prevention (HPDIP). Externally: Participated on Canadian Sport For Life Ambassador Network led by Alberta Sport Recreation Parks and Wildlife Foundation. ***Addiction and Mental Health:*** Good collaboration and relationships have developed with other internal AHS departments / programs and external stakeholders. Zone meetings with management of Addiction and Mental Health and Public Health have commenced to ensure open communication and support to staff in the Zones. Approval received for Alberta Tobacco Reduction Strategy Provincial Advisory Committee which will be co-chaired by AHW and AHS. First meeting is planned for April 15, 2010. ***Healthy Public Policy:*** Infrastructure prerequisites were completed for the operation of a provincial policy and advocacy unit to support action on the environments that impact health. These included: integrating staff; developing a consolidated action plan; developing administrative processes including leadership roles; and, articulating foundational projects. ***Environmental Public Health:*** Increased rate of restaurant inspections province wide. The team is coalescing as a province wide team and developing standards and guidelines for a comprehensive province wide program. The external Food Safety Program review is underway with stakeholder interviews completed and Phase 1 deliverables being finalized. A final report will be completed by June 30, 2010. ***Cancer Bureau – Surveillance:*** Various surveys are in progress or have launched. The Carcinogen Report on Arsenic (part of the CAREX project) was sent to stakeholders for review and feedback. *The 2009/2010 Major Initiatives were achieved but Performance Measure targets were not achieved. This was largely a result of focusing on H1N1 and there will emphasis on improving on seasonal influenza immunization coverage in the upcoming year.*

1. Improving population health

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results

Performance Measure	FY 2008/2009	FY 2009/2010	2009/2010 Targets
Influenza immunization rates:			
Seniors	58%	55.6%	60% - 75%
Children aged 6 to 23 months	43%	Reporting capability in MediTech is not yet implemented. Data currently unavailable and pending.	60% - 75%

Source: AHS

Seasonal Influenza Rates: Preliminary	2009/2010					
Seniors 65 years and older	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Total AHS
# Immunized	20,853	73,339	*24168*	77,505	19,015	214,880
Eligible	37,452	129,704	*55,232*	127,008	36,904	386,300
% Immunized	**55.7%**	**56.5%**	**43.8%**	**61.0%**	**51.5%**	**55.6%**
Long-term care: Residents	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Total AHS
# Immunized	1,143	4,251	*2,006*	4,572	1,368	13,340
Eligible	1,329	4,700	*2,199*	4,964	1,542	14,734
% Immunized	**86.0%**	**90.4%**	**91.2%**	**92.1%**	**88.7%**	**90.5%**

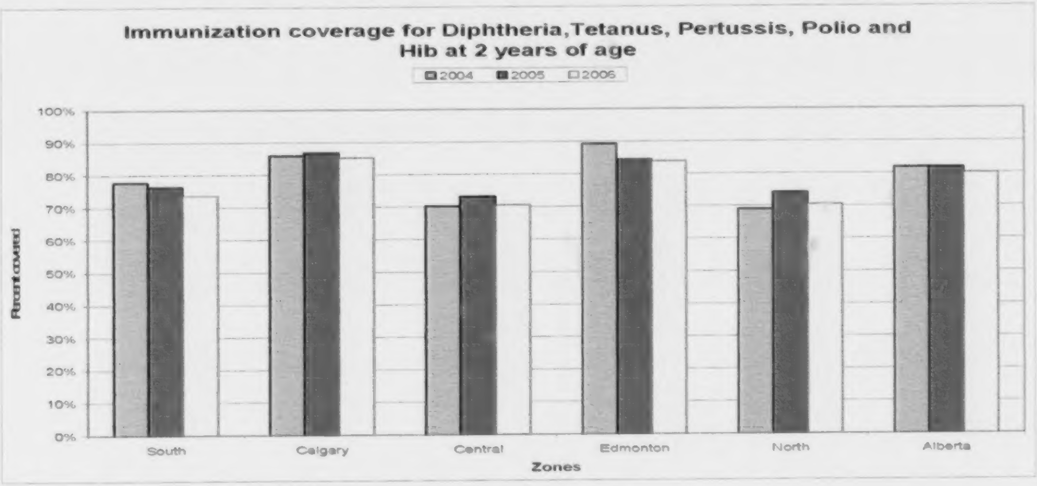
Source: AHS

1. Improving population health

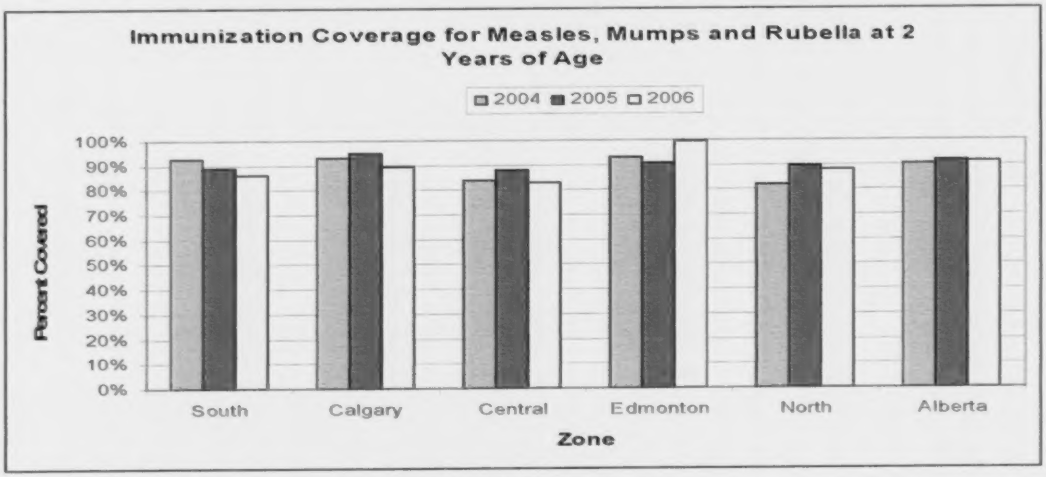
3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results

Performance Measure	2004	2005	2006	2007	2008	2009	2009/2010 Targets
Childhood Immunization coverage rates for:							
Diphtheria/Tetanus/acellular Pertussis, Polio, Hib	81.8	81.8	80.0	83.8	83.8	Data not available at time of report.	95%
Measles/Mumps/Rubella	90.3	91.7	91.0	87.9	85.0		95%

Source: Alberta Health and Wellness Interactive Health Data Application



Source: Alberta Health and Wellness Interactive Health Data Application



Source: Alberta Health and Wellness Interactive Health Data Application

Alberta Health Services

1. Improving population health

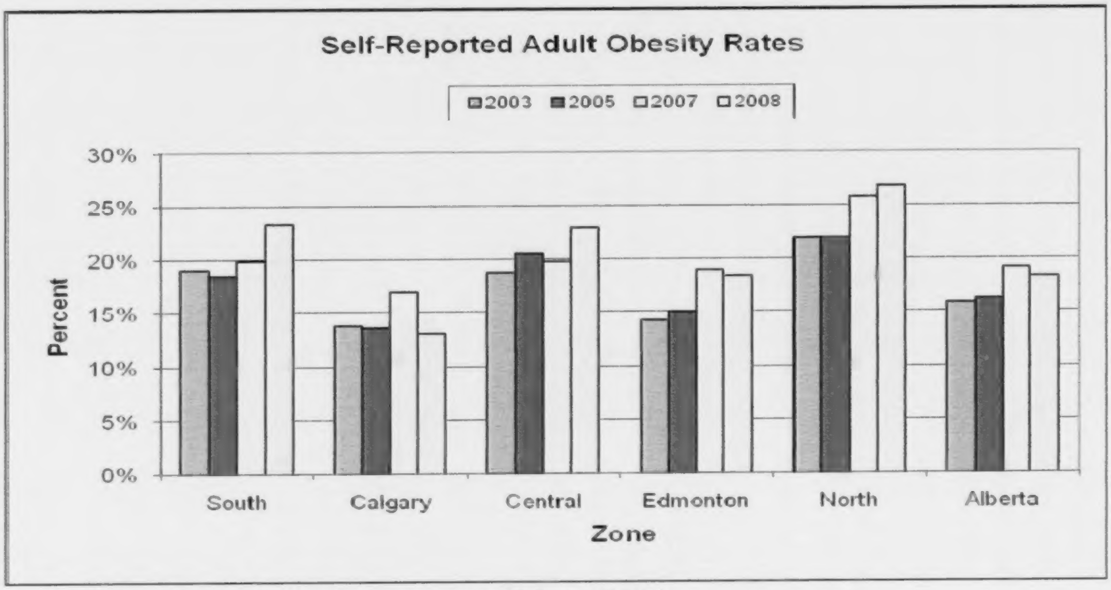
3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results

Performance Measure	Baseline 2007	2008/ 2009	FY 2009/2010	2009/2010 Targets
% of Albertans with a "normal" BMI				
Adults 18+ years	43.0%	45.00%	Data not available at time of report.	43.0%
Youth (12 – 17 years old)	83.0%	81.30%		83.0%
Prevalence of smoking (20 to 24 years old)	30.0%	28.90%		29.0%
Prevalence of heavy drinking (15 to 29 years old)	32.0%	39.00%		30.0%

Source: CCHS (2008/2009 combined with 2007/2008 was received November 2009)

NOTES:

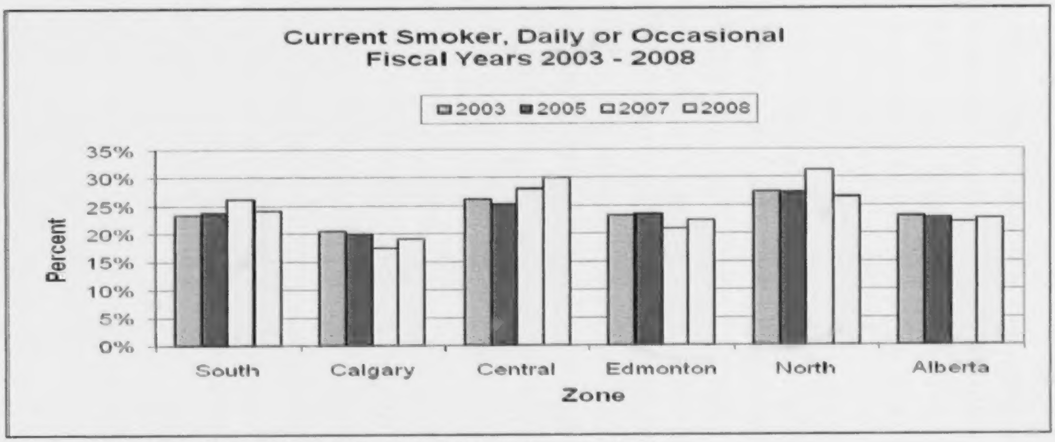
- *For youth (12 -17) the CCHS doesn't classify "normal" or "underweight" – it uses neither overweight nor obese.*
- *Prevalence of smoking (20 – 24) includes: daily, occasional (formerly daily smoking), & always occasional. The highest prevalence is found in the 25 – 29 year age group at 32.3%.*
- *Prevalence of heavy drinking – the highest prevalence of this indicator is found in the 18 – 19 year olds (56.4%) and the 20 – 24 year olds (42.4%).*



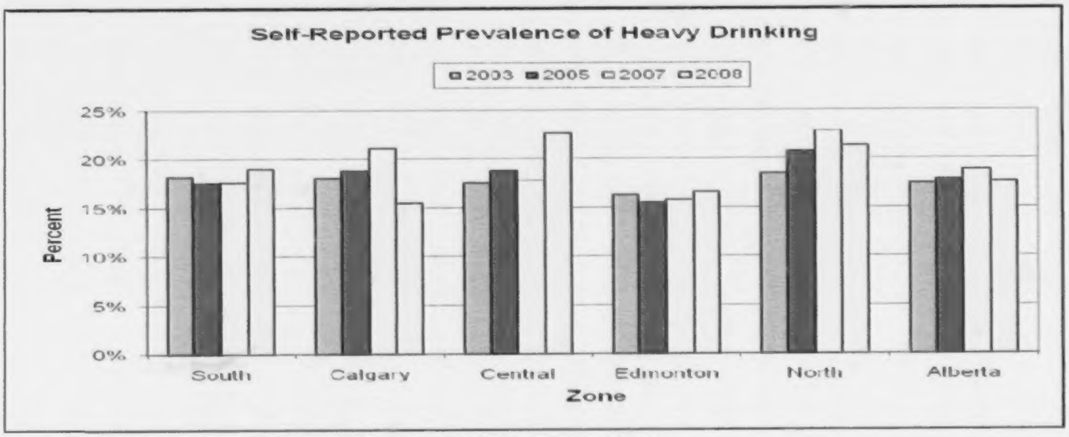
Source: Statistics Canada, Canadian Community Health Survey (CCHS)

1. Improving population health

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results



Source: Statistics Canada, Canadian Community Health Survey (CCHS)



Source: Statistics Canada, Canadian Community Health Survey (CCHS)

1. Improving population health

1.3 Responding to diverse needs

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
Ensure access throughout the province to customized health promotion and disease / injury prevention strategies that are culturally appropriate. Develop targeted programs and services to respond to diverse populations (such as prevention of low birth weight, fetal alcohol spectrum disorder, diabetes and injury). Support policies that reduce social barriers (standardized income eligibility assessments, food security, transportation, and recreation access).	Analyze best practices across the province to identify innovative models for Aboriginal populations that could be integrated into regular programming. Develop a plan to improve pre and post natal care for First Nations women.	***Reducing Disparities:*** Provincial Reducing Disparities, Diversity Competency and Health Literacy framework development and Refugee Health and Wellbeing pilot project is in progress. A Briefing Note was prepared and delivered to the CEO recommending Population & Public Health draw upon Social Determinants of Health (SDOH) frameworks to mandate addressing SDOH in a concerted way by building on current public health practice and implementing three key strategies: surveillance; advocacy; and organizational and community capacity development. ***Aboriginal Health:*** Established an Aboriginal Health Program under the umbrella of Population Health. ***Cancer Bureau – Surveillance:*** Four community cancer incidence investigations were conducted; two were completed and two are ongoing. Review and finalization of departmental procedural documentation for these requests is pending. Knowledge exchange activities were undertaken with First Nation communities. ***Primary Care and Chronic Disease Management:*** A Diverse Populations Strategy Working Group with broad representation from AHS and non-AHS stakeholders has been established to address the primary care and chronic disease needs of the diverse and vulnerable populations. *The 2009/2010 Major Initiatives were achieved.*

Performance Measure	FY 2008/2009	2009/2010 Targets
Number of First Nations women receiving formal pre and post natal care.	n/a	Approach developed & validity established
Number of customized programs for diverse populations.	n/a	Baseline established

2. Responsive to consumers and communities

The mission of AHS highlights the importance of having a health system that has the patient at its core. We must view interactions through the eyes of the consumer and strive to improve their experience through the health care system. We also need to view patients as partners in their care and appropriately involve them in decision making.

Consumers' experiences in health care are often characterized by fragmentation, duplication and system gaps. Establishing patient-focused care will help to resolve these system problems.

Albertans are passionate about the delivery of health care in this province and want to be involved. There are several avenues AHS is embracing to ensure that we are connecting with the community. This includes working with Foundations (fundraising agencies) and Health Advisory Councils. We will ensure that our investments and focus aligns with the expectations of the public, and that we work collaboratively to address issues of mutual concern. We also will recognize and respond to the diversity that exists throughout the province.

2. Responsive to consumers and communities

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
2.1 Patient experience		
Create a consistent province-wide process to track and address patient concerns. Foster a culture of patient-focused care throughout the organization.	Establish Patient Engagement Strategies & Initiatives Framework – including Network Governance Structure. Establish Provincial Patient Concerns Resolution Process. Provincial Patient Experience Survey Strategy.	***Patient Engagement Strategies:*** A draft Patient Engagement Framework has been developed. ***Patient Concerns Resolution Process:*** A Provincial Patient Concerns Resolution Process and print materials for the public have been developed. A draft Physician Patient Concerns Process is near completion. *The 2009/2010 Major Initiatives were achieved.*

Performance Measure	2004	2006	2008	FY 2009/2010	2009/2010 Targets
% of Albertans satisfied with health care services received in Alberta	51.7%	57.8%	59.7%	Data not available at time of report.	60%

Source: HQCA

2. Responsive to consumers and communities

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
2.2 Community engagement		
Create opportunities for meaningful engagement with the public including Foundations and Health Advisory Councils. Report performance and financial information in a transparent manner.	Establish 12 Health Advisory Councils.	The Alberta Health Services Board approved establishing bylaws for the 12 Health Advisory Councils. A province-wide recruitment drive was carried out, interviews were held with all applicants and members were appointed to result in all 12 Health Advisory Councils being formed and active. Formal relationship building with Foundations, Health Trusts and Auxiliaries across the province through in person meetings, issue resolution, working group formation and via request for comments through the *Alberta Health Services and Foundations / Trusts: Opportunities for Stronger Partnerships Discussion Paper* has been underway. The readiness for adopting community engagement as an enabler to meet organizational goals was assessed. A draft Framework for community engagement was created based on the assessment which includes a step by step process for undertaking the creation of a community engagement plan and is expected to be sent to the June Health Advisory Committee for review and support.
	Establish public access website that reports performance.	Consistent with our values of accountability and transparency, "Performance Reports" were created under the publications section of the public access AHS website (http://www.albertahealthservices.ca/833.asp), demonstrating the performance of AHS in managing our provincial health system. Three quarterly reports have been published: September and December 2009, and March 2010. Information provided will be expanded and enhanced over time as additional indicators become available. *The 2009/2010 Major Initiatives were achieved.*

Performance Measure	2006	2008	FY 2009/2010	2009/2010 Targets
% rating the health care system as either "excellent" or "good"				60% - 65%
% rating the health care system as "excellent"	23.7%	25.6%	Data not available at time of report.	
% rating the health care system as "good"	49.9%	47.6%		
% rating the health care system as "fair"	21.6%	21.1%		
% rating the health care system as "poor"	4.8%	5.7%		

Source: HQCA

3. Learning and Improving

Health care is ever changing. There are continual opportunities to improve the provision of high quality, safe care to positively impact outcomes and system efficiencies. We continue to embrace opportunities to learn from each other and from other jurisdictions.

While everyone strives for excellence in care, errors do occur and there are always opportunities to do things better. We are committed to promoting a "Just and Trusting Culture" in which health care providers can readily report harm, close calls and hazards, in order to promote learning and improve the safety and quality of patient care.

3. Learning and improving

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
3.1 Learning from mistakes		
Implement a process for a provincial adverse event monitoring and develop processes to support organization-wide learning. Create a climate and environment of full disclosure and fair, supportive treatment for staff, physicians, patients and families when unexpected outcomes or "near misses" occur.	Develop incident reporting system (including common definitions, common reporting processes and notification of potential hazards, etc.). Implement, in a phased approach, a single IT reporting system solution. Establish new provincial Quality Assurance Committee (QAC) structure. Develop process for monitoring and managing recommendations from quality assurance reviews. Quality and Patient Safety Dashboard established.	***Patient Safety Activities:*** Developed and implemented the initial steps of an AHS Patient Safety Approach including: • Development of an AHS Quality Assurance committee Structure. • Development and launch of Phase 1 of an AHS Reporting and Learning system for patient safety. • Development and initial implementation of a recommendation management system for AHS. • Continued real time support to clinical operations related to patient safety and adverse event management. The Executive Patient Safety Recommendation Review Committee has been established. The purpose of this committee is to review selected recommendations that arise from both internal and external patient safety quality assurance reviews that are identified as potentially requiring broad implementation and/or significant resources to implement. ***Quality and Patient Safety Performance Measures Dashboard:*** The proposed Quality and Patient Safety Dashboard was approved by the Board and released to the public in January 2010.
	Develop Health System Safety Stories for the AHS Board. Development of a provincial "Disclosure of Harm to Patients and Families" Policy. Develop and implement a Knowledge Management Framework including tools strategies and knowledge resource service.	***Accreditation:*** The Accreditation Framework is complete and implementation underway. 2010 Working groups have been set up and a Self Assessment process established and in process for Effective Organization, Infection Prevention & Control (IPC), Telehealth, Community Health, Public Health, Managing Medications, Reprocessing of Single use Devices and Governance. The remaining 20 Working Groups are set up. College of Physicians & Surgeons of Alberta (CPSA) negotiations are underway to develop service agreement for Lab and diagnostic imaging (DI) accreditation within AHS. Assessment complete on contracted providers and response related to Ministerial Directive D5 (2008). ***Disclosure Policy:*** Completed the draft policy and procedure for the disclosure of harm and broad consultation of stakeholders across AHS is underway. Engaged external stakeholders in the process including the Health Quality Council of Alberta as a core team member of the Policy Working Group. Consulted with the Alberta Medical Association, College of Physicians and Surgeons of Alberta, Canadian Medical Protective Association and other key stakeholders. ***Knowledge Management Framework:*** A draft Framework has been developed and is being tested with a clinical network. *The 2009/2010 Major Initiatives were achieved.*

3. Learning and improving

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results

Performance Measure	FY 2008/2009	FY 2009/2010	2009/2010 Targets
Timeliness of response to identified adverse events	Data not available	*Note: The Quality and Patient Safety Performance Measures Dashboard includes the development of this indicator.*	Develop incident reporting system.

3.2 Infection prevention and control

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
Optimize infection prevention and control practices and policies across the province to enhance patient care and safety. Implement hand hygiene standards. Share best practices across the organization.	Establish consistent provincial policies to support best practice in infection prevention and control Review implementation status of Alberta Infrastructure Hand Hygiene grants. Respond to patient, staff, and physician requirements in relation to Pandemic Influenza (H1N1) 2009, across sites, settings and services. Establish a baseline methicillin resistant staphylococcus aureus (MRSA) rate for acute care hospitals	During the second wave of H1N1 there were no clusters or outbreaks of healthcare associated H1N1 in acute care settings in AHS. Established AHS Infection Prevention & Control (IPC) provincial committee, co-chaired by Senior Medical Director IPC and Associate Physician Executive, with the initial meeting held on March 12, 2010. Provincial processes are established to review and assess purchase requests for equipment for disinfection and sterilization of reusable medical devices and other patient care/medical devices. An outbreak management algorithm for respiratory illness has been implemented. Algorithms for gastrointestinal illness and antimicrobial resistant organism outbreaks are in development for province-wide application. AHS policies and procedures for Hand Hygiene and Prion Disease (Creutzfeldt-Jacob Disease) Precautions for the Surgical Patient are in stakeholder consultation review. Implementation of the Alberta Infrastructure Hand Hygiene grant (extended to September 2011) continues with installation and remediation of sinks to increase hand hygiene access. Surveillance for MRSA bacterium continues and a baseline rate for 2009/2010 will be achieved by June 2010. Delays occurred due to data standardization and analysis. *The 2009/2010 Major Initiatives were not all achieved due to lack of provincial data standardization and provincial analysis. This will be a focus in 2010/2011.*

Performance Measure	FY 2008/2009	FY 2009/2010	2009/2010 Targets
Number of reported cases of MRSA infection acquired by patients in acute care hospitals in Alberta	Data not available	A province-wide surveillance program for clinical isolates of Methicillin-resistant *Staphylococcus aureus* (MRSA) is being established. Existing practices in MRSA surveillance have been reviewed, and while considerable variation was found, standardized definitions have been established. Surveillance will provide a comprehensive picture of clinical cases of MRSA, including bloodstream infections in Alberta, with a focus on hospital-acquired as well as healthcare and community associated cases. Work continues with the development of standardized province-wide data collection mechanisms, data management, storage and reporting.	Establish baseline

4. Improving access

Access to services is a major issue in Alberta. By improving access to a few key areas we will be able to improve patient flow throughout the system, provide more appropriate care to meet patient needs, decrease wait times and deliver care in a more cost effective manner.

A key concern to Albertans is a lack of access to family physicians (primary care). Provision of primary care services is the foundation for an effective health care system. This is an area we are working to strengthen in Alberta to meet current and future needs. Investing in this area will improve health outcomes, reduce demand on hospitals and address a key concern of Albertans.

Another major concern related to access is seniors care. This issue will continue to grow with the aging of our population and needs a focused multiple-strategy approach. We will offer seniors and persons with disabilities more options for quality accommodations that suit their lifestyles and service needs. By improving choice and availability of services, more capacity will be opened for acute care patients inappropriately waiting for continuing care (home care, supportive living and long-term care).

Addiction and Mental Health is another area where providing the right service, in the right place and at the right time can be improved. There are a variety of community care approaches that effectively serve individuals with mental illness. Many of these approaches have been successful in reducing emergency room and hospital visits, in providing a more cost-effective approach to care and most importantly, in improving the lives of those with mental illness and their families.

4. Improving access

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
4.1 Primary Care		
Enable physician-led and interprofessional based care in which teams of care providers are working to full scope. Strengthen processes to attach patients to primary care teams.	Develop processes to improve capacity to link unattached patients to primary care teams. Establish common elements for PCN business plans and operations. Develop transition plan to enable PCNs to align with defined elements of business plan. Finalize plan to improve access in rural areas.	Completion of the Discussion Paper comparing Primary Care Models with agreement in principle by Alberta Medical Association (AMA) leadership groups on the Enhanced Primary Care Network (PCN) model. Access Improvement Measures (AIM) has completed 10 collaboratives, with 3 in progress and another 3 scheduled for 2010. The collaboratives involved 136 clinics, 690 physicians and 23 out of 34 PCN's. Team continues to support the implementation of the Performance & Diligence Indicators (PDI) Program (Phase I – Validated Patient Lists) by participation on the steering committee Working with AIM Steering Measurement group and AHW to assist Primary Care Network (PCN) and non PCN clinics to align AIM Panel Report from AHW with the PDI validated patient list. Mechanism developed to integrate Primary Care Physicians with Clinical Networks. As of March 31, 69% of patients are attached to a PCN family physician (up 13%). It is forecasted to increase to 75% with the Letters of Intent (LOIs) presently approved or pending. *The 2009/2010 Major Initiatives were achieved.*

4. Improving access

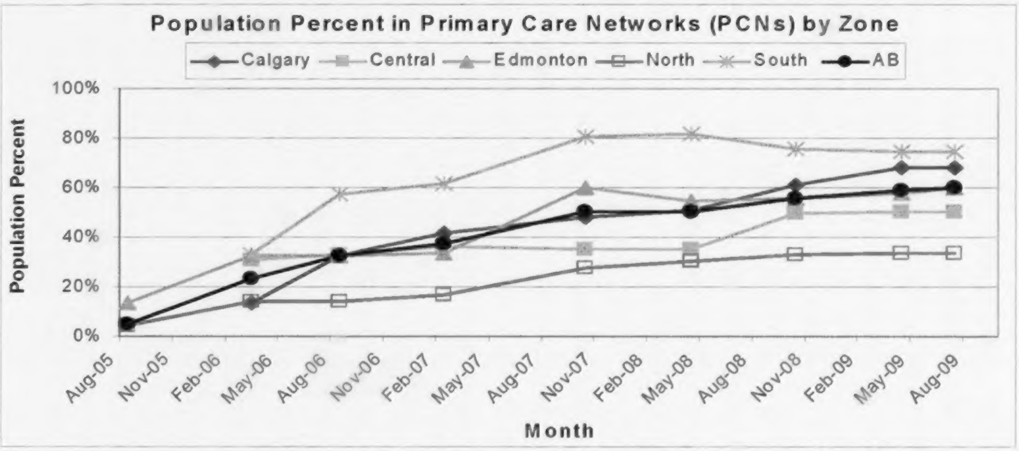
3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results

Performance Measure	2003	2004	2006	2008	FY 2009/2010	2009/2010 Targets
% of Albertans who report having a personal family physician	81.3%	84.7%	81.1%	81.1%	Data not available at time of report.	82%

Source: HQCA

Performance Measure	FY 2008/2009	FY 2009/2010	2009/2010 Targets
% of Albertans attached to a physician in a Primary Care Network	56%	69%	58% - 70%

Source: AHW



4. Improving access

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
4.2 Continuing Care		
Implement the Continuing Care Strategy which will provide Albertans more options and choices to receive health services to "age in place". Increase supportive living spaces. Invest in Home Care services to support the shift from facility to community based care.	Develop activity based funding formula to be rolled out April 2010. Implement continual assessment for all continuing care facilities. Increase supportive living spaces and home care services as per Zone plans.	***Activity Based Funding:*** Activity Based Funding (ABF) working group continues with the start of three new task groups (Quality Incentives, Data Quality and Financial / Clinical Accountability) charged with developing recommendations for Quality Incentives as part of the ABF program. Contracting, Procurement & Supply Management (CPSM) and Finance will participate in these groups. ***Seniors Living Options Guidelines:*** On January 6, 2010 the Integrated Coordinated Access and Planning team met with Zone Seniors Health Executive Directors and their respective teams to launch the *Coordinated Access to Publically Funded Continuing Care Health Services: Directional and Operational Policy*, the *Admission Guidelines for Publically Funded Continuing Care Services* and the *DRAFT Continuing Care Health Services Home and Supportive Living: Directional and Operational Policy*. From this launch, three priority actions were agreed upon: • Implement the *Admission Guidelines for Publically Funded Continuing Care Living Options*. • Re-evaluate all clients waiting in acute care and community for a living option as per the new Living Option Guidelines by March 31, 2010. • As of April 1, 2010, all clients waiting for continuing care placement will be assessed as per the new Living Option Guidelines and waitlisted as per current available living options. ***Increase Supportive Living (SL) Spaces:*** • There were increased Supportive Living spaces at Silver Willow Lodge in Nanton and at Prairie Ridge Supportive Living in Raymond. ***Other Highlights:*** • Children with Complex Health Care Needs (CCHN) review completed. • Self Managed Care (SMC) funding of $5.3 million was dispersed to support a total of 164 SMC clients. • Improvement to client flow is evident in the Emergency to Home pilot projects. • Baseline data collection underway to establish consistency and equity in Home Care across the region. • Cross-sector Case Management Framework under development. • Provincial Steering Committee established for Palliative and End of Life Care. • AHS Board approval for Progressing Seniors Health Continuing Care Strategy and 3 year Capital plans. *The 2009/2010 Major Initiatives and Performance Measure targets were not achieved. This will be an area of particular focus in 2010/2011. Significant capacity will be added to Continuing Care as well as other initiatives will be put in place to support improving access.*

4. Improving access

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results

Performance Measure	FY 2008/2009	Q1	Q2	Q3	Q4	2009/2010 Targets
Number of persons waiting in an acute care hospital bed for continuing care placement (ALC)	700	711	879	742	707	550
Number of persons waiting in community (at home) for continuing care placement	1,065	Data not available	1,027	999	1,039	1,012

ACUTE CARE:
Number of Persons Waiting in Acute Care for Continuing Care Services on the last day of the Month

Zone	2008/2009					2009/2010					
	Q1	Q2	Q3	Q4	Average	Q1	Q2	Q3	Q4	Average	TARGET
South	26	64	30	47	42	34	25	35	31	31	**34**
Calgary	237	241	274	231	246	276	331	275	243	281	**197**
Central	67	79	83	79	77	72	127	99	118	104	**62**
Edmonton	230	269	255	182	234	194	274	238	227	234	**187**
North	105	89	108	117	105	135	122	95	88	110	**84**
Provincial Total	**665**	**742**	**760**	**656**	**703**	**711**	**879**	**742**	**707**	**761**	**550**

Source: AHS "Snapshots" of the Wait List at the end of the month

COMMUNITY (AT HOME):
Number of Persons Waiting in Community (at home) for Continuing Care Services on the last day of the Month

Zone	2008/2009	2009/2010				
		Q1	Q2	Q3	Q4	TARGET
South	Data Not Available by Zone	Data Not Available	78	39	73	Targets Not Determined by Zone
Calgary			381	391	415	
Central			119	126	134	
Edmonton			307	307	315	
North			142	136	104	
Provincial Total	**1,065**		**1,027**	**999**	**1,039**	**1,012**

Source: AHS "Snapshots" of the Wait List at the end of the month

Definitions:

Number of persons waiting in an acute care hospital bed for continuing care placement: *reflects the number of individual persons assessed and approved, waiting in acute care and sub-acute, including acute care palliative and acute mental health (such as Alberta Hospital Edmonton and Centennial Centre for Mental Health and Brain Injury); for placement in long term care facilities or designated supportive living level 3, 4, and 4 dementia. These numbers are a snapshot as of the last day of the month.*

Number of persons waiting in community (at home) for continuing care placement: *reflects the number of individual persons assessed and approved, waiting in the community, for continuing care placement including those waiting for long term care facilities, designated supportive living level 3, 4, and 4, dementia. These numbers are a snapshot as of the last day of the month.*

4. Improving access

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results

Effective, March 31, 2010, individuals waiting for continuing care placement both in acute care and community were assessed according to the new "*AHS Admission Guidelines for Publically Funded Continuing Care Living Options*". Therefore, Q4 numbers reflect the number of individuals according to the: "living option guidelines", and "current available living options".

The Q4 data demonstrated:

- Persons waiting in Acute Care: only 19% were assessed for placement in long term care facilities but based on current available living options 63% were placed in long term care facilities due to lack of supportive living options available.
- Persons waiting in Community: only 5% were assessed for placement in long term care facilities but based on current available living options 45% were placed in long term care facilities due to lack of supportive living options available.

ACUTE CARE:
Patients Waiting in Acute Care for Continuing Care Services on the last day of the Quarter

Waiting in Acute/Sub-acute for:	2009/2010						
	Q1	Q2	Q3	Q4			
				Assessed According to Current Available Living Options		Assessed According to New Living Options	
				#	% of Total	#	% of Total
Facility Based care	n/a	718	563	445	**63%**	135	**19%**
Supportive Living Level 3	n/a	37	40	43	**6%**	138	**20%**
Supportive Living Level 4	n/a	124	139	174	**25%**	277	**40%**
Supportive Living Level 4 Dementia	n/a	n/a	n/a	45	**6%**	139	**20%**
Not Found	n/a	n/a	n/a	n/a		10	
Total	**711**	**879**	**742**	**707**		**699**	

Source: AHS "Snapshots" of the Wait List at the end of the month. (n/a = not available)

COMMUNITY (AT HOME):
Patients Waiting in Community for Continuing Care Services on the last day of the Quarter

Waiting in Community for:	2009/2010						
	Q1	Q2	Q3	Q4			
				Assessed According to Current Available Living Options		Assessed According to New Living Options	
				#	% of Total	#	% of Total
Facility Based care	n/a	606	554	467	**45%**	53	**5%**
Supportive Living Level 3	n/a	82	69	92	**9%**	361	**36%**
Supportive Living Level 4	n/a	339	376	437	**42%**	329	**33%**
Supportive Living Level 4 Dementia	n/a	n/a	n/a	42	**4%**	205	**21%**
Not Found	n/a	n/a	n/a	1		52	
Total	**N/A**	**1,027**	**999**	**1,039**		**1,000**	

Source: AHS "Snapshots" of the Wait List at the end of the month. (n/a = not available)

4. Improving access

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
4.3 Addiction and Mental Health		
Expand Addiction and Mental Health innovations across the province. Increase children and youth mental health services in schools and communities, reduce risk factors for special populations, and implement early intervention strategies for children and youth at risk. Reduce the harm associated with alcohol, other drugs and gambling by strengthening the availability of addiction information, prevention and treatment services.	Complete organization-wide action plan for addiction and mental health. Implement action plan.	Addiction and Mental Health (provincial and Zone) developed a three-year strategic plan with 10 priority initiatives. The plan is aligned with AHS strategic directions and government priorities. It focuses on standards, targets and initiatives that support integration and improved system performance. A draft of the plan was widely distributed to staff and stakeholders for feedback. Comments from an online survey and consultations with external stakeholders are being reviewed. Consideration will be given to all feedback, and revisions to the plan will reflect the need to balance scope with timely actions that directly benefit clients and their families. In response to amendments to the *Mental Health Act*, Addiction and Mental Health prepared for and fully implemented processes for the introduction of the Community Treatment Order Regulation (January 2010). Community Treatment Orders (CTOs) expand the continuum of addiction and mental health service options available to clients and their care providers. CTOs are intended for clients with serious and persistent mental disorders who pose significant risk to themselves or others and require intensive case management. Collaborating with Alberta Health and Wellness, other ministries and with community partners, the AHS Addiction and Mental Health CTO team: • Provided information regarding CTO legislation and processes via the AHS website and through over 35 educational sessions to physicians, families and other interested stakeholders. • Developed two manuals related to amendments to *the Mental Health Act* and the introduction of CTOs in Alberta; *A Guide to Alberta's Mental Health Act* and *The Mental Health Act: A Guide for Service Users and Caregivers* 2nd Edition. Coordination of the health services transfer from the Solicitor General to AHS continued. Addiction and Mental Health received a grant of $7.5 million (from Safe Communities) to enhance assessment, treatment and transition services for offenders in provincial correctional and remand centres. In preparation for the April 1, 2010 transfer, service delivery priorities were established, a corrections care pathway and logic model developed, and provincial level services were identified and planned. Implementation of the Children's Mental Health Plan for Alberta proceeded as planned during 2009/2010, despite some delays related to staff recruitment. With leadership provided by the Provincial Children's Mental Health Working Group, priority actions commenced across the province (rural and urban) using a collaborative approach between health services, schools and community agencies. • Staffing for 24-hour mental health crisis intervention services in Edmonton, Calgary, Fort McMurray and Brooks. • Expansion of the community response team with addition of a South Zone Aboriginal Child Life Specialist to work with clients and staff to build capacity. • Pre-natal, infant and pre-school developmental screening and early intervention to families and young children at risk for developing mental health problems. (i.e. North Zone partnership with Public Health and CASA) • Opening of eight inpatient beds for children in the Edmonton Zone that support the North Zone and work with Community Geographic Teams and transition services to provide support in the communities of origin. • Four of the nine new sites selected for the expansion of Mental Health Capacity Building (MHCB) Projects for children, youth and families in schools. Communities include Leduc, Vermillion, Janvier and a continuation of the existing project in High Prairie. • Safe and Caring Schools Society (Peer Support Model) contracted and recruitment underway for pilots in schools in Lethbridge, Camrose and Alexander First Nation.

4. Improving access

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
Continued from previous page	Continued from previous page	Several service enhancements that increased access to addiction and mental health treatment were funded through the Safe Communities Initiative during 2009/2010. • Opening of 40 addiction treatment beds for young adults. This service offers a three-month, intensive residential treatment program with family education, support and follow-up counseling components. Services are located in Calgary, St. Albert and Rocky Mountain House/ Nordegg. • Opening of 25 beds at the Centennial Centre in Ponoka with services targeted to clients with Axis IV diagnosis. Services are jointly delivered by AHS-Addiction and Mental Health and Centennial Centre medical staff. Axis IV is used to report psychosocial and environmental factors affecting the person. Some examples of these factors include: (1) problems with primary support group (divorce); (2) problems with social environment (death of a friend); (3) educational problems; (4) housing problems; (5) economic problems; (6) occupational difficulties; (7) legal difficulties; and (8) transportation difficulties. These are some categories a clinician will look at to see how the client is doing in life situations. • Introduction of Community Health Addiction Counselors who are building service capacity and supports. Hospital-based and integrated clinical counselors support concurrent disorder programming, consultation and cross training opportunities at Eastwood Health Centre (Edmonton), Alberta Hospital Edmonton, the Centennial Centre (Ponoka), Misericordia Community Hospital and Grey Nuns Community Hospital (Edmonton), Peter Loughheed and Foothills Hospital (Calgary) and Southern Alberta Forensic Psychiatry Centre. • School-based prevention counselors located in five Alberta communities. Counselors work with schools, school boards and community agencies to reduce risk factors and increase protective factors in order to foster resiliency. Counselors provide consultation, information, training, and curriculum linked resources. • Expanded addiction services and supports for the Provincial Family Violence Treatment Program. AHS Addiction and Mental Health staff play key roles in providing a coordinated screening, assessment and treatment response. • Introduction of mobile/outreach services in Edmonton and Calgary. Counselors engage and stabilize street involved individuals who are less likely to access services through traditional means. Mobile/outreach counselors work with community partners and help them to build capacity to respond to this target group. Addiction and Mental Health continued to provide effective detoxification and treatment referral for youth confined under the Protection of Children Abusing Drugs Act (PChAD). Addiction and Mental health also collaborated with AHW to amend the PChAD Act. Amendments were made in response to identified implementation and operational issues. Addiction and Mental Health commenced planning for proclamation of the PChAD Amendment Act (expected fall 2010) which will alter the admission process and increase the length of stay for youth confinement from 5 to 10 days. • During 2009/2010, 451 youth were admitted to PChAD safe houses; 244 youth (54%) continued with voluntary addiction services and 526 family members were involved in treatment. • In the 12 months preceding their admission to a safe house, almost all PChAD clients (97%) reported using alcohol and cannabis, 87% smoked tobacco, 35% had used cocaine and 24% reported use of opioids. Fiscal year results for individuals receiving addiction treatment services (AHS direct) will be available by April 30, 2010. *The 2009/2010 Major Initiatives were achieved but Performance Measure target (for Scheduled Child Mental Health) was not achieved. There will be continued emphasis on access to all mental health services (including Child Mental Health services) in the upcoming year.*

4. Improving access

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results

Performance Measure	FY 2008/2009	Q1	Q2	Q3	Q4 preliminary	2009/ 2010	2009/2010 Targets
% of Children receiving "scheduled" mental health treatment within 30 days.*	78%	75%	73%	81%	75%	76%	82%

Children seen within 30 Days at Community Mental Health Clinics

Overall (any level of urgency)	Q1	Q2	Q3	Q4 preliminary
Number of children enrolled in the quarter	1,825	1,382	1,797	1,892
Number of children seen within 30 days	1,361	1,002	1,454	1,424
% seen within 30 days	75%	73%	81%	75%

Zone Quarterly Results

Zone	Q1		Q2		Q3		Q4 preliminary	
	Enrolled	% seen within 30 days	Enrolled	% seen within 30 days	Enrolled	% seen within 30 days	Enrolled	% seen within 30 days
South*	167	74%	94	94%	181	86%	195	84%
Calgary	323	74%	363	71%	369	81%	413	77%
Central	449	87%	283	84%	399	91%	444	88%
Edmonton	394	61%	261	52%	378	69%	404	57%
North	492	75%	381	74%	470	80%	436	74%

** Excludes data from Lethbridge area of the South Zone.*

NOTES:

- *Data limited to children enrolled in programs at community mental health clinics across Alberta, excluding those clinics from the Lethbridge area of the South Zone.*
- *Data includes all scheduled, urgent and emergent cases.*
- *As a proportion of the population in Edmonton and Calgary the numbers enrolled within these Zones may appear lower than expected. This partially reflects the availability and access to other services for children in the Edmonton and Calgary Zones, data for which is not included in these figures.*

Source: AHS Mental Health Services

5. Decreasing wait times

This area is very closely connected to the previous focus of *improving access*. Long wait times are a major issue in Alberta. Two areas where pressures in the health system are currently evident and require action are in the emergency department and surgery. Solutions to these issues are much broader than within the emergency department or surgical programs themselves. We must use all available resources in the most efficient and effective manner to reduce wait times.

Some patients are not being cared for in the right setting, resulting in increased waits for needed services. Too many patients are using emergency departments for health concerns that could be handled by a primary care practitioner, and too many continuing care patients are being cared for in hospitals. This backs up admissions throughout the hospital and delays emergency department admissions and hospital services for people needing scheduled surgical procedures.

Improving the availability of continuing care resources (long term care and supportive living) for seniors will effectively increase the availability of acute beds for other patients and hence significantly decrease overall system wait times. Additionally, this is an important strategy for the quality of care of seniors as discussed under the *improving access* focus area.

5. Decreasing wait times

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
5.1 Surgery		
Review operating room utilization to ensure efficient practice. Optimize bed availability for surgical patients through system-wide initiatives to decrease length of stay. Develop specialty centres of expertise in areas with long waits. Develop strategy for equitable access to appropriate care across the province. Establish mechanisms to track and improve wait times through all steps in the care process, including through real time measures of performance.	Establish clinical network for surgery. Define information management strategy to improve OR efficiency. Define strategy to optimize access to appropriate care across the province. Decreased wait times.	***Clinical Network for Surgery:*** A Surgical Network has been established. The first meeting was held December 19, 2009. ***Information Strategy for OR Performance:*** A proposal for a province wide ORIS (operating room information system) has been developed. ***University of Alberta Hospital:*** **Surgery:** • Orthopedic Direct Admit: Decision Tree Algorithm developed to provide consistent process and safe patient admission; established clear process to access off hours clinical support services required for this patient population. **Level 3 Operating Room (OR):** • Safer Healthcare Now Surgical Bundles: • Phase 1 – Completed implementation of hair removal and maintaining 94% compliance. • Phase 2 – Maintaining Normothermia – in the monitoring phase of implementation with an 86% compliance rate. • Phase 3 – Antibiotic Administration – Baseline data gathering complete with implementation planned for April 2010 Phase. ***Foothills Medical Centre (FMC):*** • Access Targets for cancer surgery wait times were established collaboratively between the Department of Oncology and the Division of Surgical Oncology in Calgary and will be used as a guideline to inform benchmark wait times going forward. Provincial consultation is underway. • Improved operating room efficiency – 2% more surgical cases completed in 2009/2010 at FMC with a 6.5% positive variance compared to 2008/2009. *The 2009/2010 Major Initiatives and Performance Measure targets were not achieved. This will be a major focus in the upcoming year with several strategies undertaken including a surgical blitz. Work will also be undertaken regarding the Alberta Waitlist Registry.*

5. Decreasing wait times

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results

Heart Surgery (Coronary Artery Bypass Graft (CABG)) Wait Times:

Heart Surgery (CABG) % of Patients that Met Wait Times Targets:

Priority Level	Baseline March 2009 (in weeks)	Q1	Q2	Q3	Q4	2009/ 2010	Targets 2009/2010
Urgent CABG meeting target	Data Pending	51.2%	40.2%	49.6%	49.0%	46.4%	≤ 1 weeks
Semi-Urgent CABG meeting target		66.7%	56.7%	47.1%	50.0%	54.8%	≤ 2 weeks
Non-Urgent CABG meeting target		54.2%*	39.3%*	48.8%*	46.0%*	47.3%*	6 - 10 weeks

** Meeting target in the non-urgent category reflects the % meeting target of 10 weeks*

Heart Surgery (CABG) 90th Percentile Wait Times (in weeks):

Priority Level	Baseline March 2009 (in weeks)	Q1	Q2	Q3	Q4	2009/ 2010	Targets 2009/2010
Urgent 90th percentile wait times	Data Pending	2.3	2.3	2.4	2.4	2.4	≤ 1 weeks
Semi-Urgent 90th percentile wait times		6.2	4.7	6.6	8.1	7.0	≤ 2 weeks
Non-Urgent 90th percentile wait times		27.4	31.3	31.1	29.7	31.0	6 - 10 weeks

Heart Surgery (CABG) # of Patients Served:

Priority Level	Q1	Q2	Q3	Q4	2009/ 2010
Urgent CABGs Performed	131	139	131	153	401
Semi-Urgent CABGs Performed	38	36	39	56	113
Non-Urgent CABGs Performed	170	151	172	143	493
Total CABGs Performed	**339**	**326**	**342**	**352**	**1,007**

Source: AHS

NOTES:

1. *Previous data distributed last year for 2009/10 has flaws and as such "Baseline" and "Q4 2008/2009" data is unavailable at this time but will be available in the next quarter.*
2. *For individual months in the Semi-Urgent category, volumes for the individual institutions often fell below the critical number of 6 for calculating the 90th percentile. As such these metrics are not included.*
3. *Q1 and Q2 data have changed slightly after being re-calculated per AHS approved method.*
4. *Calgary had previously included their Emergent cases in the Urgent category. We have removed these cases from the Urgent category which has resulted in changes in the patient volume and wait times in the Urgent category.*

5. Decreasing wait times

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results

Joint Replacement Wait Times:

Joint Replacement wait times % of Patients that Met the Wait Times Targets:

Procedure	Q1	Q2	Q3	Q4	2009/ 2010	Targets 2009/2010
Hip replacement	86.1%	84.5%	83.9%	85.5%	85.0%	26 - 30 weeks
Knee replacement	86.6%	87.7%	85.7%	90.0%	87.5%	26 - 45 weeks

** Meeting target reflects the % meeting the high end of target range*

Joint Replacement wait times 90th Percentile Wait Times (in weeks):

Procedure	Baseline March 2009 (in weeks)	Q1	Q2	Q3	Q4	2009/ 2010	Targets 2009/2010
Hip replacement	33	37.1	38.1	37.1	36.9	37.1	26 - 30 weeks
Knee replacement	48	52.1	50.7	55.9	45.3	51.1	26 - 45 weeks

Joint Replacement wait times # of Patients Served:

Procedure	Q1	Q2	Q3	Q4	2009/ 2010
Hip replacement	683	592	665	827	2,767
Knee replacement	1,084	932	1,065	1,146	4,227

Source: AHS

NOTES:

- *Decreased volumes due to summer Operating Room (OR) closures and OR closures due to budget reduction strategies and H1N1 pandemic activity.*
- *Q1 and Q2 data was revised to reflect the addition of QEII, Lethbridge and Chinook data.*
- *Recommended Short Term Reporting: Comparable data for this measure is available for the three jurisdictions with central intake, Calgary, Red Deer and Edmonton for 75% to 80% of the joint replacements for the province.*

Definition: *The 90th percentile wait time (in weeks) for elective primary hip replacement surgery (inpatient, day surgery and contract surgical services). The wait time from decision date, to the date surgery was completed. Decision date is the date the patient and clinician agreed that surgery is the treatment option of choice.*
*The **90th percentile** refers to the number of weeks under which 90% of patients complete their wait for hip replacement surgery. That is, patients experience a wait for hip replacement surgery equal to or shorter than this 90% of the time.*
The sites that perform hip replacement surgery include:

Regional Hospitals:
- Red Deer Regional Hospital
- Queen Elizabeth II Hospital
- Chinook Regional Hospital
- Medicine Hat Regional Hospital

Tertiary Hospitals:
- University of Alberta
- Foothills Medical Centre

Metropolitan Hospitals
- Rockyview General Hospital
- Royal Alexandra Hospital
- Peter Lougheed Centre
- Misericordia Community Hospital
- Health Resource Group Inc (HRC)

Source: *AHS; DIMR from Site Surgery Wait List and Surgical Databases*

5. Decreasing wait times

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
5.2 Emergency Department		
Implement strategies to improve patient experience in the Emergency Department. Develop and implement initiatives for hospital-wide improvement of patient flow. Work with primary care, Emergency Medical Services (EMS) and Health Link to increase the number and availability of community-based services such as physician clinics and urgent care centres (facilities with expanded hours that provide care for less serious emergencies).	Establish an Emergency Clinical Network (Morph EDIT). Development of contingency plans for surge periods of patient demand. Decreased wait times.	***Emergency Clinical Network:*** An Emergency Clinical Network has been established. The first meeting was held on March 15, 2010. ***Contingency Plans for Surge:*** Major Tertiary, Metropolitan and Regional Hospitals have all developed a number of strategies to manage Emergency Department (ED) ongoing surge periods of patient demand through workforce and workflow redesign initiatives. For example, Surge Capacity Guidelines have been developed in Calgary Zone urban EDs and a response is triggered when ED admitted inpatients utilize more than 85% of ED capacity and patients must be transferred out of the ED to an acute care bed. In the Edmonton Zone urban EDs a surge capacity plan has been implemented that includes the use of over capacity spaces in the inpatient areas to accommodate ED inpatients when site specific ED activity thresholds exceed current capacity. Regional urban acute care sites have implemented contingency plans to manage surge periods of ED patient demand through adjustments in ED physician schedules to support increased patient demand and through the establishment of Fast Track care spaces for patients with a Canadian Triage Acuity Score (CTAS) of 4 and 5. ***Decreased Wait Times:*** Wait time is influenced by a complex array of factors and requires a system wide approach to identify and transform service delivery to improve access and decrease wait time. Throughout Alberta EDs, a number of system redesign initiatives were implemented involving changes to staff mix, work flow and technology. Many of the initiatives are collaborative efforts with other sectors of the health system to influence 'upstream' interventions aimed toward avoiding an unnecessary visit to the ED through providing increased community based supports as well as improving ED patient throughput and output with service and process redesign projects targeted to increase access. Ongoing assessment and evaluation of these initiatives will demonstrate the opportunity and value for expansion province wide. The Emergency Clinical Network is providing oversight to many of these initiatives and with its evolution, will lead the strategy for ED priority work provincially. *The 2009/2010 Major Initiatives and Performance Measure targets were not achieved. Much work was undertaken in the 4th quarter to introduce innovations, and reduce emergency department wait times. This will continue to be an emphasis in 2010/2011.*

5. Decreasing wait times

Performance Measure	FY 2008/2009	Q1	Q2	Q3	Q4	Calendar Year 2009	2009/2010 Targets
Length of stay from triage to discharge for Emergency Department in 16 high volume ED sites – 90th Percentile (in hours)							
Uncomplicated ED patients	5.6	5. 4	5.2	5.1	Data not available at time of report.	5.5 *	5 hours
Complicated ED patients	15.2	14.5	14.5	13.5		15.1 *	14 hours

Source: AHS

** Since Q4 data is not available, calendar year 2009 was utilized.*

Definition: *The Emergency Department (ED) length of stay (LOS) is the time from when a patient is registered until they are discharged or enter the hospital (leave the ED).*

*Cases are grouped into **complicated** and **uncomplicated** in this analysis since the resources used and the time required is expected to be quite different.*

*Patients with a more serious initial assessment (CTAS 1, 2, or 3) or requiring admission to hospital are classified as **complicated cases** as they are more likely to require more test, complexity of care, waiting for consults or surgery, or admission to an available bed.*

*Patients without a serious initial assessment (CTAS 4 or 5) and that are not admitted are classified as **uncomplicated** cases.*

*The **90th percentile** refers to the number of hours under which 90% of patients complete their ED stay. That is, patients experience an ED LOS equal to or shorter than this 90% of the time.*

The top 16 high volume sites have been identified as improvement targets regarding wait times in Emergency. The sites include:

1. University of Alberta Hospitals (Edmonton)
2. Rockyview General Hospital (Calgary)
3. Stollery Children's Hospital
4. Peter Lougheed Centre (Calgary)
5. Misericordia Community Hospital (Edmonton)
6. Alberta Children's Hospital (Calgary)
7. Royal Alexandra Hospital (Edmonton)
8. Northern Lights Regional Health Centre (Fort McMurray)
9. Grey Nuns Community Hospital (Edmonton)
10. Red Deer Regional Hospital (Red Deer)
11. Sturgeon Community Hospital (Edmonton)
12. Queen Elizabeth II Hospital (Grande Prairie)
13. Northeast Community Health Centre (Edmonton)
14. Chinook Regional Hospital (Lethbridge)
15. Foothills Medical Centre (Calgary)
16. Medicine Hat Regional Hospital

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
Implement strategies to enhance utilization of paramedic skill set and promote the integration of EMS services into the health system.	Implement programs to reduce seniors' use of emergency department. Develop provincial approach for EMS integration (dispatch, inter-facility transfer (IFT), etc.).	Significant progress has been made in the past year internal to EMS, with the completion of service transitions and dispatch consolidations. The EMS Strategic Plan should serve as the road map for the future, completed and presented to the Executive Committee in January 2010. Within AHS, significant progress was made to align the multiple operational processes inherited from former service providers to align with AHS processes being established. Significant effort was expended to identify/participate in initiatives to promote the integration of EMS into the health system. Discussions continue with departments across AHS, with various specific initiatives in progress. CHAPS – Community Health and Pre-Hospital Support (Calgary and Edmonton Zones) and PERIL (Paramedics assessing Elders at Risk of Independence Loss) are joint initiatives with Seniors Health to explore enhanced ways to identify/support at risk seniors. The initiatives were implemented in the fourth quarter, and initial results are promising. Dispatch consolidation is complete for 17 services. Further consolidations were deferred by the Minister of Health and Wellness pending outcome of review of learnings to date. Interfacility Transfer Pilots continue in both Central and South Zones. Information from the pilots will be used to inform the provincial approach to IFT to be developed under the direction of the newly established Director of Patient Transport (position begins April 2010). *The 2009/2010 Major Initiatives were achieved.*

6. Fit for the future

We recognize that we have challenges in the health system today. We need to resolve today's challenges but also address what's coming ahead. Our look into the future requires innovative thinking and actions related to people, infrastructure, technology and research.

Innovative approaches will be adopted in the way we utilize people's skills. This includes changes in the way we view the care team and support individuals to work to the full scope of their practice. We will also collaborate with all educational institutions, including universities and post secondary institutions, to ensure responsiveness to changing educational needs, worker readiness and assessment of internationally trained professionals.

Wise infrastructure investment is critical for the future. We need to ensure all investments in buildings, technologies, equipment and information technology (IT) is done with careful consideration of costs and benefits.

While there are pockets of long-standing health research excellence in Alberta, we have the opportunity to fundamentally transform the health research agenda. We need to participate fully in research initiatives with our academic partners, encourage research to further our goals and put relevant findings into practice to improve outcomes.

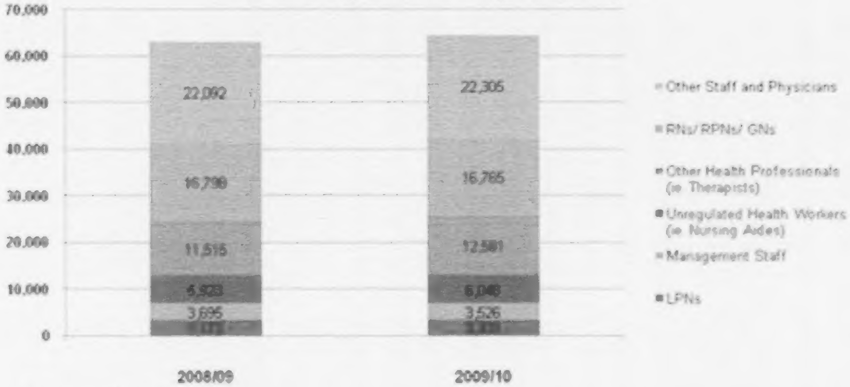
Overall we must take control of our future. We're going to have to look very carefully at everything and adopt innovations that will help us. We can not afford to pretend that we can operate as we have in the past.

Alberta Health Services

6. Fit for the future

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
6.1 Balance workforce skills with need		
Ensure optimal deployment and utilization of skills and knowledge of all health care providers. Develop a targeted approach to recruitment focusing in areas of greatest need (specialty and geographic). Improve coordination with educational institutions to ensure there is an adequate workforce with skills to meet current and future needs.	Develop a project plan to implement a work force demonstration project for March 31, 2010. Implement plan to increase number of LPNs across the province.	A revised Executive Summary and associated budget for Phase 1 of the Workplace Transformation (WPT) Initiative was approved by executive in February 2010. A robust governance structure has been established for the initiative to provide ongoing guidance and operational planning and implementation support. This includes a Provincial Steering Committee, which meets bi-weekly, as well as a Core Management Team and a Project Working Group, both of which meet weekly. A Request for Proposal (RFP) for external resources to assist with development, education and implementation of an AHS improvement method to support the WPT Initiative has been finalized and is ready to accept proposals. A number of consulting groups with Lean and other improvement expertise have expressed interest in advance of the formal RFP. Nursing and Allied Health Strategies merged to form Health Professions Strategy and Practice. This integration will improve professional practice support, improve support for operational decision making and issues resolutions related to enabling the workforce, and improve coordination between all functions related to workforce planning and practice support. Deliverables were achieved on target for both the Therapist Assistant Role Enhancement initiative and the Speech Language redesign demonstration project. *The 2009/2010 Major Initiatives were not all achieved. The infrastructure for allied health professional practice support was not established by target date of April 1, 2010 due to delays arising from the restructuring of Allied Health Strategies. A revised model for professional practice support is being reviewed by AHS Zone and Site Vice President's for feedback prior to forwarding to Executive Committee for approval. In the upcoming year, work will be focused on hiring new RN graduates and increasing the proportion of full-time staff.*

AHS Staff (Full Time Equivalents)



Source: Finance

Full time equivalents (FTE's) for staff are determined at the rate of 2,022.75 annual hours for each full-time employee.

6. Fit for the future

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
6.2 Infrastructure investment aligned		
Develop a capital plan that aligns with needs and available resources.	Develop 2010/2011 Capital Plan.	The Government of Alberta (Alberta Health and Wellness) does the capital plan with input from AHS. The AHS Capital Submission was reviewed by the Government of Alberta for consideration. The Submission was adjusted to accommodate possible Government priorities anticipated for inclusion in the upcoming AHW Capital Plan, as well as revisions to Continuing Care Capital Plan and addition of proposed Bond Funded projects. Business Cases are being developed for insertion in the final submission document which will be tabled with Government on or before June 30, 2010.
Review all existing assets (buildings, equipment and information technology) to ensure they are optimally utilized.	Develop inventory of existing assets. Develop medical equipment allocation methodology and process. Transition plan approved for divesture of major projects.	***Inventory:*** Three–year Equipment Planning Framework has been approved by the AHS Provincial Operations Group (POG). Data collection process has started. Continuing to work on the Equipment Planning portion of AHS Capital Plan. The target was achieved in developing an inventory of existing assets. In co-operation with Capital Management and BAS, Capital Management related processes were completed and approved, with work now starting to develop process maps for Equipment Sourcing – estimated completion date: end of April, 2010. Asset inventory counts were completed. ***Databases:*** Entry of all leasing information successfully completed into the new system. Training sessions for staff requiring access are underway. Transfer of project data from Excel into the Access database initiated and almost complete. Facilities Management &Engineering (FM&E) has completed the field evaluations on the following sites: Elnora, Willow Creek, Coaldale, Smoky Lake and Leduc. The field work was completed in advance of AI modeling the buildings, however the data cannot be entered into ReCAPP until the modeling is finished. ***Transition Plan:*** The Transition Plan will be completed in June 2010. The following are largely complete: • Project process document outlining stakeholder accountabilities. • Needs Assessment, Business Case and Project Charter Framework. • Agreement on the procurement of furniture, fittings and equipment has been developed between AI and AHS Contracting, Procurement and Supply Management. AHS is managing some new, major capital projects on behalf of Government such as the Stollery Children's Hospital Emergency Department Expansion, Strathcona Hospital and most recently Lloydminster Continuing Care project.
	Develop Board approved Information Technology (IT) strategy. Implement Phase 1 IT security initiative.	The Information Technology (IT) Strategy was developed with input from senior stakeholders from all AHS divisions, and endorsed by AHS Executive in late fall of 2009. The IT Strategy provided the direction for the preparation of the IT Capital Plan and implementation of key initiatives, including the launch of work to develop IT Roadmaps. This work included an assessment with the Strategy and Performance Division of the opportunity to develop TIPs (Transformation Improvement Program) Roadmaps which would identify both clinical/business and IT initiatives. The Phase 1 IT Security Initiative was completed on time and under budget. At a high level, the following was achieved: • Implemented network changes required to enable cross entity access. • Implemented the ability to grant file share access across the province. • Implemented Active Directory trusts Edmonton, Calgary, Red Deer and Cancer care. Other trusts can be implemented if required. • Provided the ability to grant province-wide access to over 20 key applications. • Created Service Desk scripts to handle new requests for cross entity application access. *The 2009/2010 Major Initiatives were not all achieved due to transition issues related to Capital Planning. New structures will be in place in 2010/2011.*

6. Fit for the future

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
6.3 Research commitment		
Lead, facilitate and implement centres of excellence with focused health research agendas that address key priorities to improve access, quality and sustainability for all Albertans. Lead and coordinate a research program that increases clinical, translational, health services and public health research outputs that are applied provincially and globally to improve health service delivery and health outcomes; the program will attract and retain world-class clinician scientists in all health professions. Lead the development of a single provincial environment that facilitates and fosters health research.	Lead in development of unified provincial research approval process. Establish the AHS research spending budget.	The AHS Board has approved the "Strategic Directions for Research" document, which will form the basis of future work on a detailed Strategic Research Plan from the Senior Vice-President, Research. Collaboration with Alberta Advanced Education and Technology (AET) and Alberta Health and Wellness (AHW) on the Alberta Health Research & Innovation Strategy (AHRIS). The AHRIS Strategy Framework will drive the provincial health research and innovation priorities to support tangible health benefits for Albertans. The "Criteria for Provincial Health Research Programs of Excellence" guidelines were developed to help identify and foster emerging province-wide health research programs in areas of importance for improving health service delivery. The work on the provincial health research ethics harmonization efforts with The Council of Chairs of The Health Research Ethics Boards of Alberta has resulted in a milestone document titled "A Strategy for Moving Forward Alberta's Health Research Ethics Boards". This proposal will provide the basis for future alignment of health research ethics in the province. Efforts to streamline health research administration provincially centre on the development of the "Alberta Clinical Trials and Research Centre" (ACTRC), a centre which will be provincial single point-of-entry for clinical trials and health research. This centre will provide a single set of policies and procedures for all clinical research administered by or impacting AHS. *The 2009/2010 Major Initiatives were achieved.*

6. Fit for the future

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
6.4 Open to innovation		
Seek global innovations and implement best practices. Embrace technology that will improve access.	Develop and implement a clinical pathway model using technology. Establish a clear health technology assessment process with established benchmarks. Develop four clinical networks. Establish an Alberta Clinical Council.	***Health Technology Assessment and Innovation Strategic Plan:*** A draft Health Technology Assessment and Innovation Strategic Plan has been developed. A clinical pathway model has yet to be developed. AHS leaders and clinical staff participated in a stakeholder session to inform the development of the Health Technology Assessment and Innovation (HTAI) Strategic Plan. Draft strategic plan with extensive stakeholder review includes defined programming in assessment, appraisal, reassessment, innovation and access through evidence development, dissemination and education. Engaged as active members of the Alberta Advisory Committee on Health Technologies and working to better define the role and responsibilities of AHW and AHS in the arena of health technology assessment. ***Safe Surgery Checklist:*** The Safe Surgery Checklist has been introduced to sites and implementation of the checklist has been initiated. Site reporting has begun, utilization rates are being measured, and evaluation is underway. ***Alberta Clinician Council and Clinical Networks:*** The successful launch of the Alberta Clinician Council took place in Edmonton on Monday, January 25, 2010 with approximately 60 clinicians and health care leaders in attendance. A Co-Chair was selected and the ACC Coordinating Team established.
Initiate systems and technologies to enable individuals to have access to their health information so they can participate in their care.	Incorporate patient portal component into overall Information Technology (IT) strategy.	The Personal Health Portal (aka "patient portal") project in Q4 moved fully from planning into executive with a number of key activities completed in Q4. • Request for Proposal (RFP) for health content released and responses evaluated. • Inventory of existing Alberta sites to be rationalized into the portal. • Technology planning for infrastructure completed. • Participation with AHW on requirements gathering for initial functionality. • First Phase charter and grant agreement signed with AHW.
	Create Telehealth Clinical Advisory Committee.	Clinical Telehealth Advisory Committee Terms of Reference was approved by Executive Vice President, Strategy and Performance, and the first meeting was held at the end of Q4.
	Implementation progress of information technology priorities:	Critical care planning underway for provincial implementation. Urgent care centre implemented with CPOE and eMAR Calgary Zone. Final stages of the Emergency Department CPOE and eMAR implementation for Calgary Zone. Clinical system selection process and engagement initiated. Plans for Edmonton Clinic South underway. Continued roll out of scheduler to Calgary Zone Clinics (10) and scheduler in Edmonton clinics (15). Clinical networks initiatives started with view to complete clinical information technology roadmaps. Transfer of Corrections staff and IT connectivity suspended by legal process. *The 2009/2010 Major Initiatives were not all achieved due to delay in developing a clinical pathway model. Clinical pathway will be a major initiative within the future Transformational Improvement Programs.*

7. Living within our means

We have made hard choices and set priorities in our spending to live within our means. We must ensure we are fiscally responsible and good stewards of resources.

Operating as one organization provides opportunities to reduce duplication and streamline our processes. We can compare and contrast more easily; to look at differences in how we do things between one end of the province and the other. We can also benefit from making it easier for services and facilities to learn from each other to improve efficiency and/or service outcomes.

We will introduce disciplined and rigorous approaches to understanding where we are spending our resources and the benefits obtained.

7. Living within our means

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
7.1 Adherence to budget		
Strengthen application of financial management controls to ensure alignment of allocated resources and expenditures. Ensure robust processes are in place to identify and mitigate financial risk. Work with Government of Alberta to develop a predictable, sustainable budget process covering both capital and operating budgets (including the operating consequences of capital decisions).	Develop action plan to implement internal control recommendations by the OAG. Develop and implement reliable cash and expenditure forecasting tools.	Monitoring and refinement of AHS's cash flow forecasting model as well as expenditure forecasting tools continue in 2010/2011. Monthly financial reporting will continue to change to meet the needs of AHS and to reflect the improvements in financial volumetric information as it becomes available. Cash flow updates will continue to be reported to the Audit & Finance Committee on a quarterly basis. Continuing with a strong working relationship between Finance and Alberta Health and Wellness and have initiated dialog and review of various financial scenarios and options to support future funding of AHS operations. AHS is also working closely with Alberta Infrastructure (AI) to provide support and funding of AHS's current and future Capital projects. ***Other Highlights:*** • AHW announced a five year plan funding that included 6% increase for each of the next 3 years and 4.5% increases for each of the remaining 2 years. • AHW provided a one-time funding of $343 million to eliminate AHS's accumulated deficit as of March 31, 2009. • The $181 million debenture to fund approved parkades was issued to Alberta Capital Finance Authority (ACFA) on March 1, 2010. AHS has also obtained a term loan from its bank to reduce short term interest costs. • Effective April 1, 2010, AHS is using the services of a single investment manager to manage its investment portfolio on a consolidated basis. • Finance successfully consolidated 10 General Ledger (G/L) centres to 3 processing hubs. *The 2009/2010 Major Initiatives were achieved.*

Performance Measure (in millions)	Year Ended March 31, 2009	2009/2010			
		Q1 YTD Actual	Q2 YTD Actual	Q3 YTD Actual	Year Ended March 31, 2010
Excess (deficiency) of revenue over expenses	$(153)	Data not published	$(301)	$(378)	$(238)
Budget (Target) 2009/2010	n/a		(356)	(450)	(885)
Budget variance*	**n/a**	**n/a**	**$55**	**$72**	**$647**

Source: AHS Finance.

* Budget variance is defined as the difference between budgeted and actual excess (deficiency) of revenue over expenses for the period.

7. Living within our means

7.2 Eliminating waste, duplication and inappropriate care

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
Reduce expenditures that add minimal value to the organization. Streamline administration to eliminate duplication.	Implement and coordinate provincial action plan for Integration Coordination Office (ICO) with targeted savings of $355 million.	AHS achieved $500 million of savings in 2009/2010 through cost containment and vacancy management programs as well as specific savings initiatives tracked through the Integration Coordination Office (ICO). Savings initiatives were comprised of: managing facilities within existing resources, strategic sourcing (procurement), and administrative restructuring including Finance, Human Resources, Corporate Services, Support Services, and Information Technology.
	Develop and implement overtime guidelines.	The Fair Management Practice (Management Rights) initiative is a multi-year project to assist management across AHS to fully and consistently exercise rights in interpreting and applying collective agreements. Guidelines on the assignment of relief shifts are ready to be implemented, pending conclusion of negotiations with the United Nurses of Alberta (UNA). Under law, there are limits to an employer's ability to change management practices while negotiations are ongoing. Appropriate assignment of relief shifts will reduce overtime costs by ensuring other options are first explored.

Performance Measure	As of March 31, 2009	2009/2010				Targets 2009/ 2010
		Q1	Q2	Q3	Q4	
Overtime costs as a % of total worked hours	*Not available as system information is still being consolidated.*					Establish baseline
Ratio of administration/management to frontline staff*	249:1,000	248:1,000	245:1,000	244:1,000	241:1,000	
Number of administration/management staff*	16,689	16,918	16,430	16,217	16,056	
Number of frontline staff*	66,929	68,256	66,945	66,581	66,545	

Source: AHS Finance and Human Resources

** Number of staff is based on headcount at a point in time.*

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
Implement a procurement strategy to optimize the buying capacity of our health system.	Develop a procurement strategy. Develop inventory of all contracts.	The projected $53 million CPSM expenditure reduction expected to be achieved for the Fiscal Year (FY) 2009/2010 was based on an annual spend assumption. The annualized FY 2009/2010 value is $40 million with $9 million rebates for a total of $49 million annualized. With inflation, $57 million of annualized savings has been generated in the current fiscal year. Procure to Pay (P2P) project began February 15, 2010. Design phase of project is underway and on schedule, with development workshops engaging stakeholders every week. Phase 1 of the Procurement Consolidation initiative is complete, with purchase orders now being issued exclusively from 4 hubs throughout Alberta. Phase 2 is in progress, on schedule, and will end no later than October 31, 2010. Engagement with affected end-users is ongoing, with special emphasis on our Covenant Health partners. Contracts for Ophthalmology, Plastic Surgery, Otolaryngology and Pregnancy Termination are complete, with requisite Ministerial Approvals received. The next steps are now underway for the input of all active contracts into the Contract Management System (CMS). The software upgrade for this system is in beta (testing) mode with training scheduled for the end of April 2010, and an anticipated launch date of end-June 2010. Collection of physical contract files is ongoing for CMS entry. Will require a robust call for contract documents from former health authorities – current non-Edmonton collection rate is at approximately 20%.

7. Living within our means

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
Redesign business and clinical processes where appropriate.	Support clinical process redesign as per Clinical Networks and develop a model to support the effective operations of Clinical Networks. This may include the development of a Quality Improvement Model, tools for clinical networks, development of clinical pathways, etc. Support Provincial Access-Improvement-Measures (AIM) collaborative in specialty care/programs. Initiate University of Alberta Hospital system flow project in conjunction with Workforce Transformation demonstration initiative.	***Support to Clinical Networks:*** Project management and service design support have been assigned to support the Bone and Joint Clinical Network in meeting deliverables. Health Technology Assessment and Innovation, at the request of the Surgical Care Network, is undertaking the assessment of the most appropriate skin prep(s) to be standardized for use across Alberta. ***Quality Improvement Models:*** **Quality Management System** The Quality Management System will describe the core processes of AHS's approach to quality/performance improvement. A draft Quality Management System document was completed March 31, 2010. **Access Improvement Measures (AIM)** Twelve AIM Specialty Clinics are enrolled in AIM Specialty. The latest Collaborative (launched February 2010) includes one Mental Health Clinic and one Pediatric Assessment Clinic at the Glenrose Hospital and the Heart Function Clinics at both the Royal Alexandra Hospital and the Mazankowski Heart Institute. ***Workplace Transformation Initiative:*** An Executive Summary and budget specific to Phase 1 of the Workplace Transformation Initiative were approved in February 2010. These documents reflected a revised mandate for the overall initiative: '*To build, communicate and deliver an integrated plan of care with each patient and his/her family*'. General Internal Medicine (GIM) at the University of Alberta Hospital (UAH) was identified as the initial prototype focus area for Phase 1 of the Workplace Transformation Initiative. A full day visioning session, focused on defining integrated plans of care, took place on March 18, 2010. More than 100 AHS leaders, physicians and staff from across the province, including the UAH, were in attendance. A workshop with international experts from Australia and England is planned for April 22, 2010 to address the issue of reassessment/disinvestment in health technologies. This will engage leaders in AHS to address opportunities, challenges, and barriers to advancing a program to manage the exit of inappropriate or unnecessary technologies in an effort to eliminate waste and inappropriate care.
Introduce equitable funding formula based on activity.	Develop proposal for activity based funding formula for acute care. Develop activity based funding formula for long term care for implementation in 2010/2011.	The proposal for acute care activity based funding formula was developed and is currently waiting engagement and validation. Activity Based Funding (ABF) – Acute Care (Inpatient): Preliminary discussions held with Data Integration, Measurement and Reporting (DIMR), The Canadian Institute for Health Information (CIHI), British Columbia Ministry of Health Services (B.C. MoHS) and a researcher from University of British Columbia (UBC) regarding how to use the Case Mix Group (CMG) + grouper and its associated Resource Intensity Weights (RIWs) for Activity-Based Funding for Acute Inpatient Care. A proposal for activity based funding for long term care was developed, approved by the Board and will be implemented on April 1, 2010. Activity Based Funding (ABF) – Long Term Care (LTC): InterRAI MDS 2.0 Resource Utilization Group (RUG) data received from all sites for Q1 to Q3 of 2009/2010. Data from each of first three months of Q4-2009/2010 was requested and is overdue, with relatively poor response rate to date. Ongoing requests for re-submission are continuing for some sites with critical data errors. Initial results using Ontario Case Mix Indexes (CMIs) are starting to be pulled. Automation of data processing to accommodate clients who have not been assessed (routine periodic assessment is supposed to be mandatory) is completed, resulting in more accurate and complete results. We need even more complete Q1-Q3 2009/2010 results before creating Alberta CMI weights. Alberta CMIs are necessary for phasing in funding in the second half of 2010/2011 for differences in client acuity. On a related topic, a new LTC Funding Advice Template was presented to several groups and distributed to field for feedback (formal feedback from field expected by third week of April 2010). Generally positive feedback received with some concern expressed over size of administration funding relative to what is funded through accommodation fees.

7. Living within our means

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
Review variance in clinical practice across the province.	Closure of specific Wait Time Management Projects (as per grant agreements) including evaluation, sharing learnings, and sustainability plans. Phased implementation of Variable Life Adjusted Display (VLAD) in select areas.	***Wait Times Management:*** A time-limited Wait Times Management (WTM) Project Management Office was established to support development of sustainability plans and project closure to remaining WTM projects. An evaluation framework to meet granting accountabilities was developed and is being implemented. Five WTM Projects have begun to implement their sustainability plans. Breast Cancer and Hip and Knee WTM projects have begun to transition learnings into the priority work of the Cancer Care and Bone and Joint Clinical Networks respectively. ***Variable Life Adjusted Display (VLADs):*** Education sessions took place in Edmonton and Calgary in late January. Four sites have been identified for implementation of the VLADs pilot in late April. Three groups of indicators were developed in consultation with clinical representatives. *The 2009/2010 Major Initiatives were achieved.*

8. Workplace of choice

One of the biggest challenges facing our organization is to attract, retain and support a strong workforce to deliver health care into the future. This workforce must be viewed in the broadest sense, and be inclusive of a wide array of health professionals and other staff who work in support areas such as finance, planning and information technology.

We must create an environment that recognizes staff as our most valuable asset, enables the best use of all people's skills and abilities, and develops the capacity to support people through the evolving nature of their careers. Working in an environment that is safe and promotes staff and physician wellness is also critically important.

People base their decisions on whether to work with, or for, a particular organization on a number of factors. With the current and future scarcity throughout the global workforce, there is a strong need for AHS to pay close attention to these factors and strive to be an employer people seek.

8. Workplace of choice

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
8.2 Staff retention		
Support the ongoing education of health care providers to enhance their knowledge and application of emerging evidence, quality improvement methodology, safety practices, technologies and services available. Regularly monitor morale and act on results.	Completion of organization-wide action plan Review options for enhancing the delivery of library services across the province including potential collaboration with the universities. Where appropriate consolidate responsibility for the administration of mandatory training under HR. Develop HR dashboard performance indicator.	The AHS Board approved AHS's Human Resources Strategy in December 2009. The strategy includes initiatives that create Change Leadership tools for Senior Leadership, a Leadership development program and an enhanced staff learning and development strategy. This will guide the organization in consolidating responsibility for the administration of mandatory training under HR where appropriate. The roles and responsibilities for compulsory training have been agreed to between HR, Nursing Strategies and Allied Health. The Request for Proposal (RFP) process for Career Transition Services was completed in February 2010. The successful vendor is Toombs, Inc. These programs will allow AHS to ensure consistency in program delivery for out placement counseling services offered to management/exempt employees who are involuntary severed from AHS. In addition, the contract provides for career transition workshops on a variety of topics such as resume writing and interviewing skills that we can offer on a broader basis to assist employees who may be affected by change. Having a single provider for these services has enabled AHS to negotiate extremely competitive pricing and cost effective program delivery. Discussions continue with University of Calgary and University of Alberta, who are meeting with AHS leaders throughout the province to develop a proposed solution to address our Library Services needs. Discussions have started regarding an integrated learning strategy that connects work and mandates across several areas such as HR, Quality, Operations (clinical educators). A strategy for consolidated reporting and consistency AHS performance indicators is being developed. The Board has requested a subset of the 24 Human Resources (HR) indicators. All 24 Human Resources (HR) indicators are under best practice review. ***Other Highlights:*** • AHS Medical Leadership structure nearing completion. • Increasing integration of physicians and physician leaders into AHS strategy setting and decision-making. • There was a net increase of 269 physicians province wide in 2009 (the last full year for which statistics are available). *The 2009/2010 Major Initiatives were achieved.*

Performance Measure	2008/2009	2009/2010					Targets 2009/2010
		Q1	Q2	Q3	Q4	2009/2010	
Staff exit rate (separation rate) **annualized for the year**	11.4% - 25.3% reflects geographic variance	10.4%	12.8%	7.6%	7.2%	9.7%	Establish baseline and target
Staff exit rate (separation rate) **for the quarter only**		2.6%	3.2%	1.9%*	1.8%		

Source: AHS Human Resources

**** Note:***

Former entities - East Central and Palliser unable to report after December 2009. Their Q3 data is repeated in Q4.

Aspen unable to report separations since November 2009.

8. Workplace of choice

3-Year Strategies	2009/2010 Target / Major Initiatives	Progress/Results
8.1 Staff and Physician satisfaction		
Develop and sustain an energizing work environment that supports professional growth and personal satisfaction. Shape the work environment to respond to issues important to staff. Establish opportunities for meaningful engagement and open communication. Create a work environment that promotes safety and wellness.	Completion of organization-wide action plan. Develop Board-endorsed 3 year human resource management plan. Complete and administer first wave of employee satisfaction/engagement survey. Complete and implement a performance management system for management that requires engagement of staff in accordance with AHS values.	Engagement Survey results have been compiled and widely shared throughout the organization. Leaders will work with their teams to identify and take steps to address, using accountability agreements areas of greatest concern. Interim performance management processes were introduced, with an extended May 2010 deadline to allow for the priorization of other year-end activities. The AHS Strategic Plan for Workplace Health & Safety (WHS) was endorsed by the Human Resources Committee of AHS Board on January 25, 2010. Implementation of the WHS Strategic Plan commenced in Q4 with presentation given to all AHS leadership teams across the province. Planning for Phase 2 of the Employee Engagement Survey, which is focused on WHS and Patient Safety, was completed in Q4. The survey is scheduled for delivery in May 2010. A new WHS Principle Statement and Policy (inclusive of the AHS WHS Management System Standard) was developed, and put forward to the Executive Committee for review and approval in April 2010. AHS received government grants for two WHS initiatives in 2008. The Reduction & Avoidance of Injury Initiative and Safe Patient Handling Program are both focused on prevention of musculoskeletal injury to healthcare workers as a result of patient handling. Significant gains have been realized on the above projects: • Request for Proposal (RFP) for major and minor equipment are at the evaluation and awarding stage. Equipment will be ordered in Q1 2010/2011. • The AHS Safe Client Handling program was developed. Implementation will commence in April 2010.
		Other Highlights: • The majority of the senior medical leadership structure was established and recruited to (Senior Physician Executive (SPE), Associate SPE, Zone Medical Directors, Senior Medical Directors, etc). The senior non-physician components of the Medical Affairs team were also filled (Vice President, Senior Leader, Provincial Integration, Zone Leaders). • Physicians participated in the AHS Workforce/Physician Engagement Survey. *The 2009/2010 Major Initiatives were achieved. The focus for 2010/2011 will be to improve upon the newly established targets for engagement and injury rate.*

Performance Measure	2008/2009	2009/2010 Established Baselines	Established Targets for 2010/2011
Staff and physician satisfaction[1]	Not Available		
Staff Overall Engagement		35% Favorable	43%
Physician Overall Engagement		26% Favorable	43%
Volunteer Overall Engagement		79% Favorable	43%
Staff injury rate (Disabling Injury Rate)[2]		2.83	2.41

[1] *Workforce Engagement Survey conducted from January 27, 2010to February 15, 2010.*

[2] *Working with WCB to establish a mechanism to acquire disabling injury frequency for all of AHS. Source: AHS Human Resources*

Surgical Contracts and Province Wide Services

Non-Hospital Surgical Facility Contracts under the Health Care Protection Act (Alberta)

Alberta Health Services (AHS) contracts with multiple non-hospital surgical facilities (NHSF) to provide insured surgical services for dermatology, ophthalmology, oral maxillofacial, otolaryngology, plastic surgery, orthopedic and pregnancy terminations. The use of NHSF's enables AHS to obtain quality services to enhance surgical access and alleviate capacity pressures within AHS main operating rooms.

Alberta Health Services determines if the contract is appropriate by assessing sustainability of the public system, access to services, patient safety, appropriateness, effectiveness, cost and public benefit. Contracts with NHSF's provide increased choice of service provider for patients and supplement the resources available in hospitals, while providing good value for public dollars.

The following table summarizes the contracts by service area for 2009/2010.

Edmonton Zone - Surgical Contracts	Number of Operators	Total Annual Contract Value (thousands of dollars) (unaudited)	Number of Procedures Performed	Total Annual Expenditures (thousands of dollars) (unaudited)
Dermatology	1	$ 279	139	$ 287
Ophthalmology	5	1,042	2,101	1,004
Oral & Maxillofacial Surgery	9	768	1,822	735
Otolaryngology (ENT)	1	184	92	51
Plastic Surgery	2	296	922	230
Pregnancy Termination	1	2,715	5,833	2,715
Total	19	$ 5,284	10,909	$ 5,022

NOTE: The above numbers are preliminary pending final numbers. The actual expenditure amounts have not exceeded the approved annual value of the contract amounts. The difference relates to the timing of contract dates and AHW authorized surgical volume uplift January-March.

Calgary Zone - Surgical Contracts	Number of Operators	Total Annual Contract Value (thousands of dollars) (unaudited)	Number of Procedures Performed	Total Annual Expenditures (thousands of dollars) (unaudited)
Ophthalmology	6	$ 11,912	12,712	$ 7,168
Oral & Maxillofacial Surgery	9	231	529	231
Orthopedic	1	25,500	1,045	9,638
Pregnancy Termination	1	1,790	4,289	1,807
Total	17	$ 39,433	18,575	$ 18,844

NOTE: The above numbers are preliminary pending final numbers. The actual expenditure amounts have not exceeded the approved annual value of the contract amounts. The difference relates to the timing of contract dates and AHW authorized surgical volume uplift January-March.

Province Wide Services

With the restructuring of the health regions in 2008, Province Wide Services (PWS) funding was incorporated into the global funding for AHS. The majority of the historical PWS funding was allocated to the clinical and capital operating units responsible for the services. Specialized procedures will continue to be delivered in Calgary and/or Edmonton and, where appropriate, in some Regional Hospitals.

Financial Overview

Financial Statement Analysis

For the year ended March 31, 2010

(in millions of dollars)

Purpose

This Financial Statement Analysis is provided to enable readers to assess Alberta Health Services' (AHS) results of operations and financial condition for the year ended March 31, 2010 compared to budget and to the preceding year.

This Financial Statement Analysis should be read in conjunction with the audited consolidated financial statements, notes and schedules and is dated June 10, 2010. The consolidated financial statements are prepared in accordance with Canadian generally accepted accounting principles and reporting requirements of Financial Directives issued by Alberta Health and Wellness (AHW). All amounts are in millions of dollars unless otherwise specified.

Additional information about AHS including financial reports from prior periods is available on the AHS website at www.albertahealthservices.ca.

Overview of 2009/2010

The following table summarizes the Consolidated Statement of Operations:

Consolidated Statement of Operations	Budget 2010	Actual 2010	Variance	Actual 2009	Increase (Decrease)
Revenue	$9,768	$10,239	$471	$9,586	$653
Expenses	10,653	10,477	(176)	9,742	735
Deficiency of revenue over expenses before transfer	(885)	(238)	647	(156)	(82)
Transfer of HBA Services	-	-	-	3	(3)
Deficiency of revenue over expenses	$ (885)	$ (238)	$647	$ (153)	$ (85)

The AHS operating deficit for the year ended March 31, 2010 is $238. Results are significantly improved from the budgeted operating deficit of $885 due mainly to the additional funding received from AHW in the amount of $397 to fund the opening accumulated deficit upon transition and for H1N1 costs. Other contributing factors that influenced financial performance are operating costs associated with front line patient care, Emergency Medical Services (EMS) services, H1N1, labour agreements, additional costs to transfer employee groups from Public Service Pension Plan (PSPP) to Local Authorities Pension Plan (LAPP) and other inflationary increases in excess of funding. These additional costs have been offset by stringent vacancy management initiatives; various cost control measures and considerable effort across the organization to reduce discretionary spending in the areas of general supplies, education and workshops, other contracted services, minor equipment and sundry expenditures.

The AHS accumulated deficit is $527 and the year-end unrestricted cash balance is $314. The accumulated deficit is largely comprised of the $343 opening deficit, the current year operating deficit, and is offset by transfers related to internally funded capital assets. The unrestricted cash balance at year-end is better than expected mainly due to the reduced operating deficit.

In order to facilitate management of the organization's cash flows and ongoing requirements, AHS is continuing discussions with AHW on its operating and capital funding arrangements and is continually assessing working capital requirements, expenditure plans and borrowing options. There was a working capital deficiency of $515 at March 31, 2010 as compared to a deficiency of $399 as at March 31, 2009. The organization presently has access to an unutilized $220 line of credit.

Statement of Operations

Revenue

Revenue	Budget 2010	Actual 2010	Variance	Actual 2009	Increase (Decrease)
Alberta Health & Wellness contributions	$8,430	$8,883	$453	$8,228	$655
Other government contributions	81	81	0	66	15
Fees and charges	585	578	(7)	543	35
Ancillary operations	108	123	15	118	5
Donations	16	18	2	25	(7)
Investment and other income	247	251	4	283	(32)
Amortized external capital contributions	301	305	4	323	(18)
Total revenue	$9,768	$10,239	$471	$9,586	$653

Total 2010 revenues increased by 6.8% from 2009 and were higher than budgeted amounts by 4.8%. This increase was primarily due to increased contributions received and recognized from AHW during 2010. $8,883 of revenues were sourced from AHW, representing 87% of total revenues in 2010, as compared to $8,228 and 86% in 2009. Other sources of revenues listed totaled $1,356 in 2010 or 13%, compared to $1,358 or 14% in 2009.

Significant variances are explained as follows:

- **Alberta Health & Wellness (AHW) contributions** are either unrestricted or restricted in nature. Unrestricted funding is the main source of operating funding to provide health care services to the population of Alberta and is approximately 87% of total revenue for AHS. Restricted funding is revenue that can only be used for specific projects and is recognized when the related expenses are incurred.

  AHW contributions resulted in a positive variance of $453 as compared to budgeted levels mainly due to funding the opening accumulated deficit, H1N1 response costs and various other restricted projects.

  AHW contributions increased by $655 in 2010 compared to 2009 due to an increase in base operating funding, funding received for 2009 net accumulated deficit elimination, increase in funding related to taking over the delivery of EMS in 2010, increased funding received related to H1N1 response, new Alternate Relationship Plan agreements, and additional Alberta Infrastructure funding.

- **Other government contributions** is ongoing and one-time contributions for operating purposes from federal, provincial (other than AHW) and municipal governments.

  The increase in other government contributions of $15 as compared to the prior year is due to an increase in the cost of accommodation of provincial buildings, as well as an increase in the receipt and usage of funds for infrastructure projects and the workforce action plan.

- **Fees and charges** consist of patient revenue for health services at rates set by the Minister of Health and Wellness and collected by AHS and contracted long-term care providers from individuals, Workers Compensation Board (WCB), federal and provincial governments, and other responsible parties such as Alberta Blue Cross and insurance companies.

  The $7 negative variance in fees and charges is due to less than expected revenue from out-of-province patients and WCB, as well as higher than budgeted bad debt expense.

  The increase of $35 as compared to the prior year is mainly attributable to the fees and charges being charged for EMS services that are now part of AHS.

- **Ancillary operations** include parking, non-patient food services and the sale of goods and services.

  The $15 positive variance is mainly attributed to higher than expected rental revenue, sales of goods and services and parking revenue.

- **Donations** include contributions from foundations and voluntary donations for non-capital purposes that are restricted and unrestricted.

  The decrease of $7 as compared to the prior year is mainly due to a decrease in donations received from the Alberta Cancer Foundation.

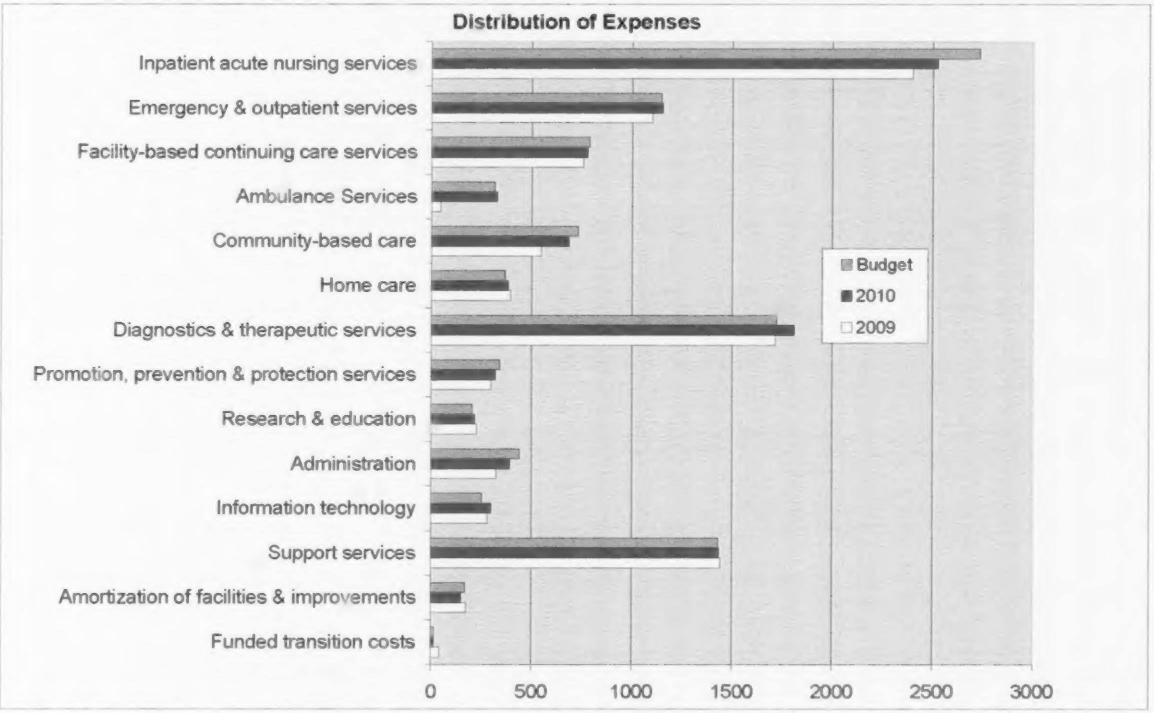
- **Investment and other income** is comprised of interest income, dividends, net realized gains and losses on disposal of investment, recoveries and revenue from drug companies, medical supply companies, and universities, and other non-government grants.

  The decrease of $32 from the prior year is due to reduced recoveries in various departments, as well as a reduction in WCB special dividends based on experience ratings.

- **Amortized external capital contributions** are the restricted revenue recognized from external agencies for capital assets that are amortized during the period.

  The main reason for the $18 decrease, as compared to the prior year, is the recording of loss on disposal of equipment, as well as the reduction in amortization of minor equipment.

Expenses – By Program



Total expenses in 2010 increased by 7.5% from 2009 and were lower than budgeted amounts by 1.7%. This increase was primarily due to labor and contract inflation, increased usage of overtime, increased volumes and expansion of services. AHS's distribution of expenses has remained consistent with the previous year with inpatient acute nursing services and diagnostic and therapeutic expenses making up over 40% of total expenses. The largest increases as compared to the prior year were seen in ambulance services with the transition of EMS to AHS, community-based care, inpatient acute nursing services and administration.

Significant variances are explained as follows:

- **Inpatient acute nursing services** is comprised predominantly of nursing units, including medical, surgical, intensive care, obstetrics, pediatrics and mental health. This category also includes operating and recovery rooms.

  Inpatient acute nursing services resulted in a positive variance of $209 as compared to the budget mainly due to vacancy management, savings initiatives during the year particularly related to long-term care providers and procurement strategies, and actual spending was under budget in the area of new facilities.

  There was also a $125 increase as compared to the prior year mainly due to labor inflation and increased surgical and medical activity.

- **Emergency and outpatient services** are comprised primarily of emergency, day/night care, clinics, day surgery, and contracted surgical services.

  There is an increase of $53 over prior year due to increased costs related to inflation and growth mainly in clinics, emergency and day/night care.

- **Facility-based continuing care services** are comprised of long-term care including chronic and psychiatric care operated by AHS and contracted providers.
- **Ambulance services** are comprised of EMS ambulance, patient transport, and EMS central dispatch.

  Ambulance services resulted in a negative budget variance of $10 mainly due to the impact of collective agreement consolidation for EMS staff.

  The increase in ambulance services costs of $282 as compared to the prior year is mainly due to EMS services transitioning to AHS effective April 1, 2009. The prior year costs related to one-time project costs, as well as set-up and preparation costs in anticipation of the transfer completion.
- **Community-based care** is comprised primarily of supportive living, and palliative and hospice care. This category also consists of community programs, primary care networks (PCN's), urgent care centres, and community mental health.

  Community-based care has a $45 positive variance compared to budgeted spending mainly due to vacancy management, various savings initiatives and lower activity, and drug usage for patients served in long-term care facilities. The redeployment of staff to H1N1 activities also contributed to the overall surplus, which is offset by an increase in expenses in promotion, prevention and protection services.

  The increase in community-based care of $139 as compared to the prior year is mainly due to labor contract inflation and an increase in community addiction services.
- **Home care** is comprised of home nursing and support.

  The negative budget variance of $15 is mainly due to an increase in home living and self managed care activity.
- **Diagnostic and therapeutic services** is comprised primarily of clinical lab (both in the community and acute), diagnostic imaging, pharmacy, acute and therapeutic services such as physiotherapy, occupational therapy, respiratory therapy and speech language pathology.

  The negative variance of $87 is mainly due to amortization costs incurred in excess of budget as well as clinical savings targets not yet fully achieved.

  The increase from the prior year of $93 is mainly attributable to significant activity increases including clinical laboratory services, MRIs and rehabilitation services. Further increases were incurred as a result of union salary increases and increased radiology fees.
- **Promotion, prevention and protection services** is comprised primarily of health promotion, disease and injury prevention, health protection, and emergency preparedness which includes H1N1 planning and preparedness.

  Promotion, prevention and protection services resulted in a positive variance of $23 compared to budget due to continued vacancy management and health promotion and education savings initiative implementation, partially offset by increased costs for H1N1 immunization clinics, influenza assessment clinics and H1N1 supply costs.

  The increase from the prior year of $20 is mainly due to the emergency preparedness activity related to H1N1.
- **Research and Education** pertains to formally organized health research and graduate medical education, primarily funded by donations and third party contributions.

  The negative variance of $12 as compared to the budget is mainly attributable to increased research spending of grant funds related to addictions and cancer, partially offset by reduced spending in the area of formal medical nursing education.

  The decrease from the prior year of $11 is mainly related to an overall decrease in formal education for medical, administrative and support services.

- **Administration** is comprised of human resources, finance and general administration.

  A positive variance of $50 as compared to the budget is due to vacancy management initiatives and savings targets achieved through initiatives such as the Finance geographic consolidation strategy. Cost containment efforts to decrease discretionary spending helped achieve the positive variance. The major cost savings were in the areas of consulting services, travel, and education/sundry expenditures.

  Administration increased by $66 from the prior year mainly due to the impact of transferring employer groups from PSPP to LAPP, as well as transition expenses related to the merger of the former health authorities and boards.

- **Information technology** is comprised of infrastructure and systems support, device and print services, data processing, system development and software.

  The negative variance of $48 as compared to the budget is mainly due to amortization costs in excess of budget.

  The increase of $18 as compared to the prior year is attributable to the centralization of expenses during the year and an expansion of services to a growing organization.

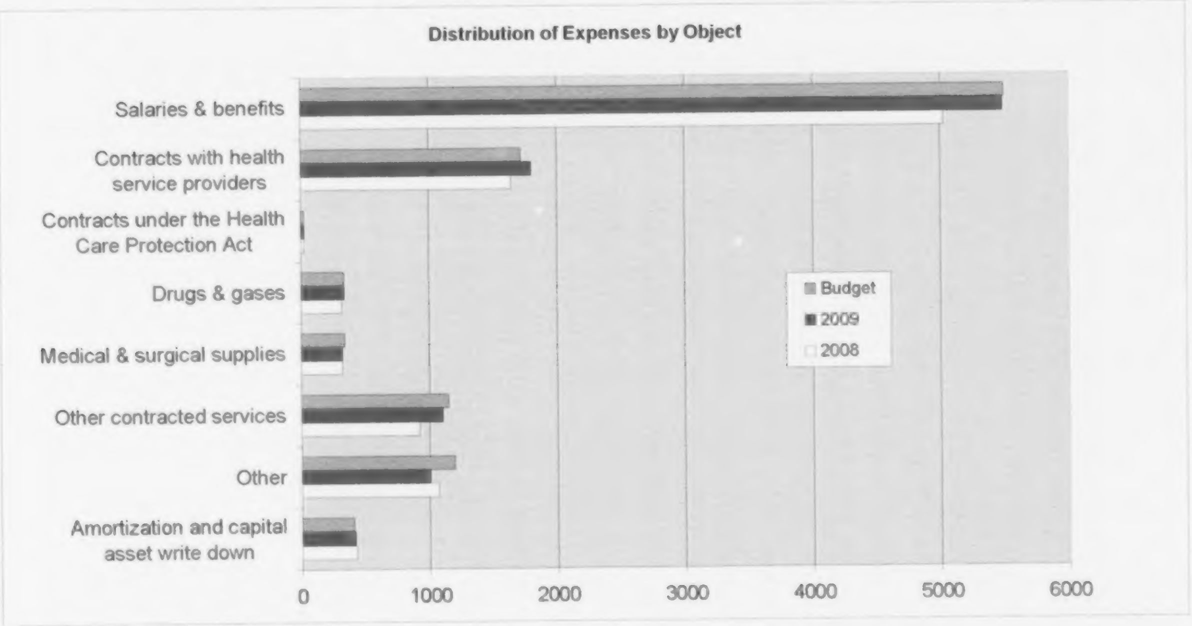
- **Support services** is comprised of building maintenance operations (including utilities), materials management (including purchasing, central warehousing, distribution and sterilization), housekeeping, laundry and linen services, patient registration, health records and food services.

- **Amortization of facilities and improvements** is comprised of amortization of buildings, building service equipment and land improvements capitalized by AHS (exclusive of the portion of amortization charged to ancillary operations). Amortization of equipment is not disclosed separately on the statement of operations, but is instead included in each of the other expense classifications above.

  The positive variance of $20 is mainly due to achieving consistencies in the methodology of calculating amortization on fixed assets of all the former health entities.

  The decrease of $14 as compared to the prior year is also due to achieving consistencies in the methodology of calculating amortization on fixed assets of all the former health entities.

Expenses – By Object



The distribution of expenses by object has remained consistent with the prior year, with salaries and benefits making up more than half of total expenses.

Significant variances are explained as follows:

- **Salaries and benefits** comprises worked hours, non-worked (benefit) hours which includes vacation and sick leave, base salary which includes pensionable base pay, other cash benefits, which includes overtime, employee benefit contributions made on behalf of employees and severance.

  Salaries and benefits were higher in 2010 by $461 as compared to the prior year mainly due to inflation, expansion of services and new initiatives, increase in benefit expenses, increase staffing expenses related to the H1N1 activity and the transfer of EMS resulting in increased staffing positions.

- **Contracts with health service providers** include voluntary and private health service providers with whom AHS contracts for health services.

  The negative variance of $83 as compared to the budget mainly relates to higher than expected inflation impacts, various one-time grants and operator funding provided to various continuing care providers and long-term care operators, the costs attributed to two daily assisted living centres that opened in 2010, and higher than anticipated home care hours.

  Contract expenses for health service providers were higher in 2010 by $160 due to inflation, increase in facility and community-based beds, increased home care activity, grant payments to continuing care providers and long-term care operators, and increased volume and rates related to laboratory. Increased costs also resulted from the opening of new supportive living facilities.

- **Contracts under the Health Care Protection Act** relates to contracts with surgical facilities pursuant to the Health Care Protection Act which is about ensuring more efficient delivery of publically funded services by allowing contracting out to profit-orientated surgical facilities.

- **Drugs and gases** expenses include all drugs used by AHS, including medicines, certain chemicals, anesthetic gas, oxygen and other medical gases used for patient treatment. Drugs used for other than patient treatment are not considered to be part of this category, but rather included in other expenses.

  The increase in costs of $16 as compared to the prior year mainly relates to the increase in drug usage related to cancer care.

- **Medical and surgical supplies** are those used throughout the province, including prostheses, instruments used in surgical procedures and in treating and examining patients, sutures and other supplies.

  Medical and surgical supply expenses resulted in a positive variance of $16 as compared to the budget mainly due to lower-than-anticipated activity levels and increased savings initiatives.

- **Other contracted services** are payments to those under contract that are not considered to be employees. This category includes fee-for-service payments to physicians, referred-out services and purchased services.

  The increased expenses in 2010 of $180 as compared to the prior year were due to inflation, new Alternate Relationship Plan agreements, and the transfer of EMS to AHS.

- **Other expenses** relate to those not classified elsewhere.

  The significant positive variance of $191 as compared to the budget was mainly due to overall cost savings initiatives, decreased sundry expenditures, decreased travel expenditures and decreased market utility rates.

  The decreased costs experienced in the current year of $66 as compared to the prior year relates mainly to significant decrease in energy rates, decrease in sundry expenses and increased savings initiatives related to patient transport and travel expenses. These savings were partially offset by increased lease costs.

- **Amortization expenses** relates to the periodic charges to expense representing the estimated portion of the cost of the respective physical asset that expired through use and age during the period.

Statement of Financial Position

The following table summarizes the Consolidated Statement of Financial Position:

Consolidated Statement of Financial Position	Actual 2010	Actual 2009	Increase (Decrease)
Current assets	$1,386	$1,477	$(91)
Non-current assets	7,389	7,508	(119)
Total assets	$8,775	$8,985	$(210)
Current liabilities	$1,901	$1,876	$25
Non-current liabilities	6,746	6,788	(42)
Net assets	118	311	(193)
Endowments	10	10	0
Total liabilities and net assets	$8,775	$8,985	$(210)

Current assets decreased in 2010 due to a decrease in cash and cash equivalents resulting mainly from the deficiency of revenue over expenses, partially offset by an increase in contributions receivable from AHW and an increase in pandemic inventory held.

The decrease in **non-current assets** is mainly due to a decrease in non-current cash and investments, partially offset by an increase in capital assets. Since most capital projects are externally funded, capital expenditures increase both capital assets and unamortized external capital contributions, which is included in non-current liabilities. This increase in **non-current liabilities** is more than offset by a decrease in deferred capital contributions, mainly due to the spending of external funds on capital projects. An increase in long-term debt contributed to some increase in non-current liabilities, further offset by decreases in deferred contributions and other liabilities. The main reason for the decrease in other liabilities is the funding of supplemental pension plans.

Current liabilities increased mainly due to the timing of payments related to accounts payable, growth of program expenditures, accruals related to restructuring costs, salary increases and an increase in statutory benefits payable on accrued vacation pay. The increase in current liabilities was partially offset by a decrease in deferred operating contributions, resulting from increased recognition of revenues related to prior deferred grants.

Net assets decreased significantly from the prior year mainly due to the current year operating deficit of $238, partially offset by significant net cumulative unrealized gains on investments of $17 (as compared to losses of $18 for 2009).

Working Capital

Working Capital	Actual 2010	Actual 2009
Total current assets	$1,386	$1,477
Total current liabilities	$1,901	$1,876
Working Capital ratio	0.73	0.79

Working capital is defined as the ratio of current assets over current liabilities. A ratio greater than 1.0 indicates that, if necessary, all current liabilities would be covered by liquidating current assets. The main reason for the decreased working capital ratio is the current year deficit.

A portion of current liabilities are attributable to capital expenditures which are funded by restricted funds held in non-current cash and investments and capital contributions receivable. AHS receives its monthly funding in advance on the first of the month and invests the cash to maximize investment income until required to meet its current obligations.

Capital Assets

Capital assets	Actual 2010	Actual 2009	Increase (Decrease)
Cost	$9,902	$9,084	$818
Accumulated amortization	3,751	3,545	206
Net book value	$6,151	$5,539	$612

The total unamortized capital assets as at March 31, 2010 consist of $124 of land and land improvements, $3,135 of facilities, $711 of equipment and building service equipment, $266 of information systems, $91 of leased facilities and improvements and $1,824 of work in progress. The work in progress consists of $391 for the South Health Campus, $362 for the Foothills Medical Centre expansion, $181 for the University of Alberta Hospital Edmonton Clinic, $150 for the Royal Alexandra Hospital North Treatment Centre, $114 for the Rockyview General Hospital expansion, $83 for the South Health Campus parkade, $67 for the Royal Alexandra Hospital Surgical Centre, $46 for the Garrison Green extended care facility, $45 for the Foothills Medical Centre Lot 10 parkade and $385 for other capital expenditures.

The estimated remaining useful life for equipment and information systems decreased from 3.4 years to 3.2 years; the estimated useful life for facilities increased from 18.6 years to 21.8 years in 2010. The capital purchases compared to the annual amortization expense indicates the rate of reinvestment; the reinvestment rate for equipment and information systems was 86% in 2010 (2009 – 141%) and for facilities was 514% in 2010 (2009 – 506%).

Equipment purchased in 2010 amounted to $218 and was funded 83% externally and 17% internally (2009 amount of $330 was funded 58% externally and 42% internally). Facility expenditures were $805 in 2010 and were funded 88% externally, 1% internally and 11% debt-funded (2009 purchases were $849 funded 85% externally, 8% internally and 7% debt-funded). AHS relies significantly on external sources for funding capital expenditures.

AHS has approved capital commitments of $1,595 for facilities and improvements, $28 for information systems and $49 for equipment.

Statement of Cash Flows

The following table summarizes the Consolidated Statement of Cash Flows:

Consolidated Statement Of Cash Flows	Budget 2010	Actual 2010	Variance	Actual 2009	Increase (Decrease)
Operating activities	$(1,077)	$(172)	$905	$523	$(695)
Investing activities	(622)	(230)	392	(1,574)	1,344
Financing activities	474	235	(239)	1,495	(1,260)
Increase (decrease) in current cash and cash equivalents	$(1,225)	$(167)	$1,058	$444	(611)
Current cash and cash equivalents, beginning of year	1,049	1,144	95	700	444
Current cash and cash equivalents, end of year	$(176)	$977	$1,153	$1,144	$(167)

The cash position, comprised of cash and temporary investments, has decreased to $977 from $1,144 in 2009. This is primarily the result of the following:

Cash flows from operating activities relate to the inflow and outflow of cash from the organization's internal activities. The net amount of operating cash flows is derived by adjusting the deficiency of revenues over expenses to reverse non-cash items like amortization expense, write down of capital assets, amortization of external capital contributions and any changes in non-cash working capital balances.

Operating cash flows experienced a positive variance as compared to budget mainly due to the change in non-cash working capital and lower than expected operating deficit.

Operating cash flows decreased in 2010 as compared to 2009 mainly due to the higher operating deficit and change in non-cash working capital.

Cash flows from investing activities relate to the inflow and outflow of cash from transactions associated with the acquisition or sale of non-current assets. Activities that affect investing cash flows include the purchase and sale of capital assets and investments, as well as any allocations related to non-current cash.

Investing cash flows resulted in a positive variance as compared to the budget mainly as a result of significantly lower capital purchases and lower allocations from non-current cash, partially offset by decreased proceeds on the net purchase and sale of investments.

The increase in investing cash flows as compared to the prior year was also mainly due to lower capital purchases, significantly higher allocations from non-current cash, and increased proceeds on the net purchase and sale of investments. The overall increase was partially offset by a negative change in non-cash working capital.

Cash flows from financing activities relate to the inflow and outflow of cash from external activities that mainly relate to debt and net assets.

Financing cash flows experienced a negative variance from budget mainly due to less capital contributions received and less proceeds from long-term debt in the year.

Financing cash flows were lower as compared to the previous year mainly due to significantly less capital contributions received in the year, partially offset by higher proceeds from long-term debt.

Financial Reporting

2009-10 was the first year for AHS as an entity. On May 15, 2008 the Minister of Health and Wellness restructured the governance model of health services delivery in Alberta. Effective April 1, 2009 the nine regional health authorities, two regional health boards and Alberta Alcohol and Drug Abuse Commission were disestablished and all the assets, liabilities, rights and obligations of these entities were amalgamated into AHS. Planning and implementation is underway on multi-year projects to convert the multiple legacy financial, procurement and human resource systems into one integrated province wide source of information.

The AHS consolidated financial statements have been prepared in accordance with Canadian generally accepted accounting principles and the financial directives issued by AHW. For example, the Schedule of Salaries and Benefits and the Unaudited Schedule of Facilities and Sites are required by AHW. The chart of accounts that AHS uses to report expenses by program and by object is based on the national standard of the Canadian Institute of Health Information. Detailed site based results are submitted to CIHI annually for analysis on Canada's health system and the health of Canadians.

AHS started public reporting of unaudited quarterly results with the quarter ended September 30, 2009. Quarterly and annual financial reports are available at www.albertahealthservices.ca under publications.

The Auditor General is the appointed auditor of AHS. In addition to expressing an audit opinion on the AHS annual consolidated financial statements, the Auditor General also reports to the legislature significant recommendations related to AHS along with other government entities. The Auditor General's reports are available at www.oag.ab.ca under public reports.

Outlook into Fiscal 2010-11

Fiscal 2010-11 marks the start of a new time in health funding in Alberta. For the first time, the provincial government has agreed to funding certainty over a five-year period in contrast to the typical annual cycles. The new five-year funding agreement allows AHS to plan over a longer time horizon.

The 2010-11 provincial government budget increased the allocation to AHS by funding at the level at which it was operating in 2009-10. The provincial government also increased base funding by 6% for each of the next 3 years and by 4.5% for each of the remaining 2 years. In addition one time funding was provided to address the 2009-10 accumulated deficit. Overall, this process provides AHS with the ability to make long-term plans, while continuing to maintain budget control.

The 2010-11 focus is on stabilizing operations, targeting savings, and furthering specific improvements identified within the Health Plan with new funding. However, providing a complex array of quality health services tailored to individual and population needs generates significant inherent risks to maintaining a balanced budget. AHS is committed to providing these services and mitigating financial risks.

Given that the AHW base funding is AHS's primary source of revenue, the five-year funding agreement with the Province mitigates a significant portion of the overall revenue risks.

The AHS expense budget is comprised largely of human resource costs, arising from both staff salaries and benefits, as well as contracted health service provider staff. As negotiated collective agreements are in place for almost all unions, the only one posing a risk is the United Nurses of Alberta (UNA) contract, which is currently being negotiated. Risks will be mitigated through the collective bargaining process. The risks associated with the expenses for contracted health service providers will be managed and mitigated through the introduction of activity-based funding over a number of years starting in 2010-11 with long-term care facilities. This will improve transparency of funding and tie funding to activity.

Overall, AHS is striving to improve the health status of Albertans, while improving value.

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2010

Management's Responsibility for Financial Reporting

Auditor's Report

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Schedule 5 – Unaudited Consolidated Schedule of Facilities and Sites

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

MARCH 31, 2010

The accompanying consolidated financial statements for the years ended March 31, 2010 and 2009 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Generally Accepted Accounting Principles and the financial directives issued by Alberta Health and Wellness, and of necessity include some amounts based on estimates and judgment.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising written policies, standards and procedures, a formal authorization structure, and satisfactory processes for reviewing internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained, and assets are adequately safeguarded.

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit and Finance Committee. This Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to the Alberta Health Services Board for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Audit and Finance Committee.

The Auditor General of Alberta provides an independent audit of the consolidated financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures which allow him to report on the fairness of the consolidated financial statements prepared by management.

"Original signed"

Dr. Stephen Duckett
President and Chief Executive Officer
Alberta Health Services

"Original signed"

Chris Mazurkewich
Executive Vice President and Chief Financial Officer
Alberta Health Services

June 10, 2010

AUDITOR GENERAL
Alberta

Auditor's Report

To the Members of the Alberta Health Services Board
and the Minister of Health and Wellness

I have audited the consolidated statements of financial position of Alberta Health Services as at March 31, 2010 and 2009 and the consolidated statements of operations, changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of Alberta Health Services' management. My responsibility is to express an opinion on these financial statements based on my audits.

I conducted my audits in accordance with Canadian generally accepted auditing standards. Those standards require that I plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In my opinion, these consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2010 and 2009 and the results of its operations and its cash flows for the years then ended in accordance with Canadian generally accepted accounting principles.

[Original signed by Merwan N. Saher]
CA
Auditor General

Edmonton, Alberta
June 10, 2010

CONSOLIDATED STATEMENT OF OPERATIONS
FOR THE YEAR ENDED MARCH 31, 2010

	2010		2009
	Budget (Note 3)	Actual	Actual (Note 4 (b))
Revenue:			
Alberta Health and Wellness contributions	$ 8,430,022	$ 8,883,012	$ 8,227,662
Other government contributions	80,980	81,422	66,646
Fees and charges	584,991	577,644	542,616
Ancillary operations	108,581	123,059	117,652
Donations	15,668	17,775	25,373
Investment and other income (Note 5)	246,984	250,907	282,682
Amortized external capital contributions	300,635	305,054	322,930
TOTAL REVENUE	9,767,861	10,238,873	9,585,561
Expenses:			
Inpatient acute nursing services	2,733,440	2,523,753	2,398,751
Emergency and outpatient services	1,146,381	1,151,994	1,099,206
Facility-based continuing care services	787,862	778,485	756,230
Ambulance services	315,918	326,319	43,970
Community-based care	730,069	684,790	545,980
Home care	367,807	383,224	393,159
Diagnostic and therapeutic services	1,723,008	1,810,102	1,717,480
Promotion, prevention and protection services	340,389	316,867	296,994
Research and education	203,659	215,872	227,366
Administration	439,696	390,154	324,356
Information technology	251,160	299,059	280,950
Support services	1,431,988	1,432,600	1,441,658
Amortization of facilities and improvements	167,584	147,338	161,391
Capital assets write down (Note 9 (c))	-	2,682	13,810
Funded transition costs (Note 6)	13,900	13,804	40,561
TOTAL EXPENSES (Schedule 1)	10,652,861	10,477,043	9,741,862
Deficiency of revenue over expenses before transfer	(885,000)	(238,170)	(156,301)
Transfer of HBA Services (Note 4 (a))	-	-	3,116
Deficiency of revenue over expenses	$ (885,000)	$ (238,170)	$ (153,185)

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31, 2010

	2010 Actual	2009 Actual (Note 4 (b))
ASSETS		
Current:		
Cash and cash equivalents (Note 8)	$ 977,216	$ 1,144,223
Accounts receivable	166,807	159,221
Contributions receivable from Alberta Health and Wellness	79,233	36,183
Inventories	108,339	91,109
Prepaid expenses	54,903	46,044
	1,386,498	1,476,780
Non-current cash and investments (Note 8)	999,614	1,807,319
Capital contributions receivable from Alberta Health and Wellness	109,947	16,500
Capital assets (Note 9)	6,151,112	5,539,407
Other assets (Note 10)	127,613	144,786
TOTAL ASSETS	$ 8,774,784	$ 8,984,792
LIABILITIES AND NET ASSETS		
Current:		
Accounts payable and accrued liabilities	$ 963,139	$ 902,723
Accrued vacation pay	357,410	330,599
Deferred contributions (Note 11)	567,727	630,620
Current portion of long-term debt (Note 13)	12,938	12,068
	1,901,214	1,876,010
Deferred contributions (Note 11)	163,250	181,346
Deferred capital contributions (Note 12)	1,046,140	1,696,776
Long-term debt (Note 13)	262,766	189,216
Unamortized external capital contributions	5,254,711	4,675,230
Other liabilities (Note 14)	18,431	45,424
	8,646,512	8,664,002
Net assets:		
Accumulated deficit (Note 16)	(527,235)	(343,219)
Accumulated net unrealized gains (losses) on investments	17,243	(17,737)
Internally restricted net assets invested in capital assets	628,114	671,596
Operating net assets	118,122	310,640
Endowments (Note 17)	10,150	10,150
	128,272	320,790
TOTAL LIABILITIES AND NET ASSETS	$ 8,774,784	$ 8,984,792

Commitments and contingencies (Note 18)

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET ASSETS FOR THE YEAR ENDED MARCH 31, 2010

	2010						2009
	Accumulated deficit (Note 16)	Accumulated net unrealized gains/(losses) on investments	Internally restricted net assets invested in capital assets	Sub-total operating net assets	Endowments (Note 17)	Total	Total (Note 4 (b))
Balance at beginning of year	$ (343,219)	$ (17,737)	$ 671,596	$ 310,640	$ 10,150	$ 320,790	$ 514,735
Deficiency of revenue over expenses	(238,170)	-	-	(238,170)	-	(238,170)	(153,185)
Capital assets purchased with internal funds	(43,200)	-	43,200	-	-	-	-
Amortization of internally funded capital assets	106,740	-	(106,740)	-	-	-	-
Repayment of long-term debt used to fund capital assets	(10,495)	-	10,495	-	-	-	-
Transfer of land from unamortized external capital contributions	-	-	5,723	5,723	-	5,723	-
Purchase of land	-	-	-	-	-	-	3,327
Net unrealized gains (losses) arising during the period on investments	-	39,382	-	39,382	-	39,382	(45,727)
Transfer of net realized losses (gains) on investments to revenue	-	(4,402)	-	(4,402)	-	(4,402)	3,707
Net repayment of life lease deposits	(604)	-	604	-	-	-	-
Reclassification adjustments	1,713	-	3,236	4,949	-	4,949	(2,067)
Balance at end of year	$ (527,235)	$ 17,243	$ 628,114	$ 118,122	$ 10,150	$ 128,272	$ 320,790

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED MARCH 31, 2010

	2010		2009
	Budget (Note 3)	Actual	Actual (Note 4 (b))
Operating activities:			
Deficiency of revenue over expenses	$ (885,000)	$ (238,170)	$ (153,185)
Non-cash transactions:			
Amortization expense, loss on disposal and write down (Schedule 1)	466,000	411,585	427,651
Amortized external capital contributions	(300,000)	(305,357)	(322,930)
Other	9,000	(41,979)	37,367
Changes in non-cash working capital	(367,000)	1,520	534,023
Cash generated from (used by) operating activities	(1,077,000)	(172,401)	522,926
Investing activities:			
Purchase of capital assets:			
Internally funded equipment	(150,000)	(36,097)	(139,449)
Internally funded facilities and improvements	(50,000)	(7,103)	(70,278)
Externally funded equipment	(144,000)	(181,573)	(190,616)
Externally funded facilities and improvements	(1,177,000)	(708,985)	(721,483)
Debt funded facilities and improvements	(96,000)	(89,107)	(56,742)
Purchase of investments	-	(341,196)	(374,668)
Proceeds on sale of investments	134,000	412,688	347,079
Allocations from (to) non-current cash	884,000	775,595	(419,192)
Changes in non-cash working capital	(31,000)	(53,911)	54,322
Other	8,000	(329)	(2,951)
Cash generated from (used by) investing activities	(622,000)	(230,018)	(1,573,978)
Financing activities:			
Capital contributions received	294,000	160,992	1,452,584
Proceeds from long-term debt	190,000	88,830	55,417
Principal payments on long-term debt	(10,000)	(14,410)	(10,119)
Other	-	-	(2,386)
Cash generated from (used by) financing activities	474,000	235,412	1,495,496
Net increase (decrease) in current cash and cash equivalents	(1,225,000)	(167,007)	444,444
Current cash and cash equivalents, beginning of year	1,049,000	1,144,223	699,779
Current cash and cash equivalents, end of year	$ (176,000)	$ 977,216	$ 1,144,223

The accompanying notes and schedules are part of these consolidated financial statements.

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2010

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established April 1, 2009 under the *Regional Health Authorities Act* (Alberta). Effective April 1, 2009, Aspen Regional Health Authority, Calgary Health Region, Capital Health, Chinook Regional Health Authority, David Thompson Regional Health Authority, Northern Lights Health Region, Palliser Health Region, and Peace Country Health were disestablished along with the Alberta Cancer Board, Alberta Mental Health Board, and Alberta Alcohol and Drug Abuse Commission. All the assets, liabilities, rights and obligations of the disestablished entities were assumed by East Central Health, whose name changed to Alberta Health Services.

Effective April 1, 2009 the operations and administration of emergency medical services (EMS) within the Province of Alberta (Province) were transitioned from Alberta Health and Wellness (AHW) to AHS.

AHS's mission is to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans. AHS's operations include the facilities and sites listed in Schedule 5. AHS is a registered charity under the Income Tax Act and is exempt from the payment of income tax.

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

The financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles and the reporting requirements of AHW's Financial Directive 1.

These financial statements have been prepared on a consolidated basis. Included in these consolidated financial statements are the following wholly owned subsidiaries:

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(i) Calgary Laboratory Services Ltd. (CLS), who provides medical diagnostic services in Calgary and Southern Alberta.
(ii) Capital Care Group Inc. (CCGI), who manages continuing care programs and facilities in the Edmonton area.
(iii) Carewest, who manages continuing care programs and facilities in the Calgary area.
(iv) 1115399 Alberta Inc. (operating as Chemical Exposure Support Services), Capital Health Tele-Ophthalmology Inc., and Edmonton Heart Systems Inc. were amalgamated into AHS effective December 31, 2009.

The transactions between AHS and these subsidiaries have been eliminated on consolidation. All consolidated entities of AHS are exempt from the payment of income tax.

AHS uses the proportionate consolidation method to account for its 50% interest in the Northern Alberta Clinical Trials Centre joint venture with the University of Alberta, and its 50% interest in the Primary Care Networks disclosed in Note 19 (b).

These consolidated financial statements do not include the assets, liabilities and operations of controlled foundations (Note 19 (c)), or voluntary or private facilities providing health services in the Province (Note 19 (d)). These consolidated financial statements do not include trust funds administered on behalf of others (Note 20).

(b) Revenue Recognition

These consolidated financial statements have been prepared using the deferral method of accounting for contributions; the key elements of our revenue recognition policies are:

(i) Unrestricted contributions are recognized as revenue in the year receivable.

(ii) Externally restricted non-capital contributions are deferred and recognized as revenue in the year the related expenses are incurred.

(iii) Externally restricted capital contributions are recorded as deferred capital contributions until invested in capital assets. Amounts expended, representing externally funded capital assets, are then transferred to unamortized external capital contributions. Unamortized external capital contributions are recognized as revenue in the year the related amortization expense of the funded capital asset is recorded.

(iv) Contributions receivable from Alberta Health and Wellness and capital contributions receivable from Alberta Health and Wellness are recorded as receivable when confirmed with AHW.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(v) Endowments and externally restricted contributions to purchase capital assets that will not be amortized are treated as direct increases to net assets.

(vi) Investment income includes dividend and interest income, and realized gains or losses on the sale of investments. Unrealized gains and losses on available for sale investments are included directly in net assets or deferred contributions as appropriate, until the related investments are sold. Restricted investment income is recognized as revenue in the year in which the related expenses are incurred. Other unrestricted investment income is recognized as revenue when earned.

(vii) Donations and contributions in kind are recorded at fair value when such value can reasonably be determined.

(viii) Revenue from sales of goods and services is recorded in the period that goods are delivered or services are provided.

(c) Full Cost

AHS accounts for all costs of services for which it is responsible. Full cost transactions comprise the following:

(i) Revenue earned by contracted health service providers from AHW designated fees and charges are recorded as AHS's fees and charges. An equivalent amount is recorded as program expenses as this revenue funds part of the cost of AHS's programs.

(ii) AHW payments directly to contracted health service providers are recorded as revenue and an equivalent amount is recorded as program expenses as these payments represent part of the cost of AHS's programs.

(iii) The estimated cost for use of acute care facilities not owned by AHS is recorded as revenue from other government contributions and as program expenses, since AHS's contract payments do not include an amount for the use of these facilities.

(iv) The estimated cost for use of non-acute care facilities not owned by AHS and provided to AHS at zero or nominal rent is recorded as other government contributions and as program expenses.

(v) Other assets, supplies and service contributions that would otherwise have been purchased are recorded as revenue and expenses, at fair value at the date of contribution, when a fair value can be reasonably determined. Volunteers contribute a significant amount of time each year to assist AHS in carrying out its programs and services. However, contributed services of volunteers are not recognized as revenue and expenses in the consolidated financial statements because fair value cannot be reasonably determined.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(d) Inventories

Inventories for consumption or distribution at no charge are valued at lower of cost (defined as moving average cost) and current replacement value. All other inventories are valued at lower of cost (defined as moving average cost) and net realizable value.

(e) Investments

Investments are accounted for in accordance with the accounting policies described in Note 2(f). Transaction costs associated with the acquisition and disposal of investments are capitalized and are included in the acquisition costs or reduce proceeds on disposal. Investment management fees are expensed as incurred. The purchase and sale of investments are accounted for using trade-date accounting.

(f) Financial Instruments

AHS has classified its financial assets and financial liabilities as follows:

Financial Assets and Liabilities	Classification	Subsequent Measurement and Recognition
Cash and cash equivalents	Held for trading	Measured at fair value with changes in those fair values recognized in the Consolidated Statement of Operations.
Investments	Available for sale	Measured at fair value with changes in fair values recognized in the Consolidated Statement of Changes in Net Assets or deferred contributions until realized, at which time the cumulative changes in fair value are recognized in the Consolidated Statement of Operations.
Accounts receivable	Loans and receivables	After initial fair value measurement, measured at amortized cost using the effective interest rate method.
Accounts payable, long-term debt, and life lease deposits	Other financial liabilities	After initial fair value measurement, measured at amortized cost using the effective interest rate method.

AHS does not use hedge accounting and is not impacted by the requirements of Canadian Institute of Chartered Accountants (CICA) accounting standard Section 3865 – Hedges. AHS as a not-for-profit organization has elected to not apply the standards for embedded derivatives in non-financial contracts.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

When it is determined that an impairment of a financial instrument classified as available for sale is other than temporary, the cumulative loss that had been recognized directly in net assets or deferred contributions is removed and recognized in the Consolidated Statement of Operations even though the financial asset has not been derecognized. Impairment losses recognized in the Consolidated Statement of Operations for a financial instrument classified as available for sale are not reversed.

The carrying value of current cash and cash equivalents, accounts receivable, accounts payable, and short-term borrowings approximate their fair value because of the short term nature of these items. Unless otherwise noted, it is management's opinion that AHS is not exposed to significant interest, currency or credit risks arising from its financial instruments.

Further disclosure on financial instruments is provided in Note 2(e) Investments, Note 8 Cash, Cash Equivalents and Investments, and Note 13 Long-term Debt.

(g) Capital Assets

Capital assets and work in progress are recorded at cost. Capital assets acquired from other government organizations are recorded at the carrying value of that government organization. Capital assets with unit costs less than five thousand dollars are expensed. Information systems with unit costs less than two hundred and fifty thousand dollars are expensed.

Capital assets are amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Facilities and improvements	10-40 years
Equipment	2-20 years
Information systems	3-5 years
Leased facilities and improvements	term of lease
Building service equipment	5-30 years
Land improvements	5-25 years

Work in progress, which includes facilities and improvements projects and development of information systems, is not amortized until after a project is complete. Leases transferring substantially all benefits and risks of capital asset ownership are reported as capital asset acquisitions financed by long-term obligations.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(h) Asset Retirement Obligations

AHS recognizes the fair value of a future asset retirement obligation as a liability in the period in which it incurs a legal obligation associated with the retirement of tangible long-lived assets that results from the acquisition, construction, development, and/or normal use of the assets. AHS concurrently recognizes a corresponding increase in the carrying amount of the related long-lived asset that is amortized over the life of the asset. The fair value of the asset retirement obligation is estimated using the expected cash flow approach that reflects a range of possible outcomes discounted at a credit-adjusted risk-free interest rate.

Subsequent to the initial measurement, the asset retirement obligation is adjusted at the end of each period to reflect the passage of time and changes in the estimated future cash flows underlying the obligation. Changes in the obligation due to the passage of time are recognized as an operating expense using the effective interest method. Changes in the obligation due to changes in estimated cash flows are recognized as an adjustment of the carrying amount of the related long-lived asset that is amortized over the remaining life of the asset.

An asset retirement obligation related to the removal of hazardous material that would be required as part of a capital project is only recognized when there is approval from the Minister of Health and Wellness to proceed with the project.

(i) Employee Future Benefits

AHS participates in the following registered benefit pension plans: the Local Authorities Pension Plan (LAPP) and the Management Employee Pension Plan (MEPP). These multi-employer public sector final average plans provide pensions for participants, based on years of service and earnings. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). As these plans are multi-employer plans and sufficient information is not available, these plans are accounted for on a defined contribution basis.

AHS administrates a defined contribution pension plan (DC plan) for certain employee groups. AHS also sponsors Group Registered Retirement Savings Plans (GRRSPs) for certain employee groups. Under the DC plan and GRRSPs, AHS matches a certain percentage of any contribution made by plan participants up to certain limits. These plans provide participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS sponsors three defined benefit Supplemental Pension Plans (SPPs) which are funded. These plans cover certain employees and supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). A majority of the SPPs are final average plans, however, certain participant groups have their benefits determined on a career average basis. Also, some participant groups receive post-retirement indexing similar to the benefits provided under the registered defined benefit pension plans; while others receive non-indexed benefits. The obligations and costs of these benefits are determined annually through an actuarial valuation as at March 31 using the projected benefit method pro-rated on service and management's best estimate assumptions, including a market-related discount rate. Due to *Income Tax Act* (Canada) requirements, the SPPs are subject to the Retirement Compensation Arrangement (RCA) rules, therefore approximately half the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SPPs are invested in a fixed income portfolio.

The net benefit cost of SPP's reported in these financial statements include the current service cost, interest cost on the current service cost and obligations, as well as the amortization of past service cost, initial obligations and net actuarial gains and losses. These amounts are offset by the expected return on the plans' assets.

Past service costs, including the initial obligations of the plans, are amortized on a straight-line basis over the average remaining service lifetime of the relevant employee group. Cumulative net actuarial gains or losses over 10 percent of the greater of the benefit obligation and fair value of the plans' assets, are amortized on a straight-line basis over the average remaining service lifetime of the employee group. When an employee's accrued benefit obligation is fully discharged, all unrecognized amounts associated with that employee are fully recognized in the net benefit cost in the following year.

Employees who participate in the MEPP and whose benefits are limited by the *Income Tax Act* (Canada) are eligible to participate in the Supplementary Retirement Plan for Public Service Managers (SRP) for post July 1, 1999 service. AHS ceased contributions to the SRP on April 1, 2009.

AHS provides its employees with basic life, accidental death and dismemberment, short term disability, long term disability, extended health, dental and vision benefits through benefits carriers. AHS's contributions are expensed to the extent that they do not relate to discretionary reserves. AHS fully accrues its obligations for employee non-pension future benefits.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(j) Internally Restricted Net Assets Invested in Capital Assets

AHS discloses internally restricted net assets invested in capital assets separately on the Consolidated Statement of Financial Position and Consolidated Statement of Changes in Net Assets. The AHS Board has approved the restriction of net assets equal to the net book value of internally funded capital assets that will be amortized.

(k) Grants for Research and Other Initiatives

AHS awards grants to other organizations for research and other initiatives. The term of the grants range from less than one year to more than one year. AHS records the committed value of the grant awarded as an expense when it has been approved and when the agreement between AHS and the principal investigator has been executed.

(l) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. The amounts recorded for amortization of capital assets and amortization of external capital contributions are based on the estimated useful life of the related assets. The amounts recorded for asset retirement and employee future benefits obligations are based on estimated future cash flows. Actual results could differ materially from these estimates.

(m) Capital Disclosure

For operating purposes, AHS defines capital as including working capital and unrestricted net assets. For capital purposes, AHS defines capital as including deferred capital contributions, long term debt, unamortized external capital contributions, and internally restricted net assets invested in capital assets.

AHS's objectives for managing capital are:

- In the short term, to safeguard its financial ability to continue to deliver health services; and
- In the long term, to plan and build sufficient physical capacity to meet future needs for health services.

The majority of AHS's operating funds are from AHW which is paid on the first of each month. As a result, significantly less working capital is required. AHS monitors and forecasts its working capital and cash flow.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHW approves health care facilities based on long-term capital plans and provides the majority of the funding through one-time capital grants. AHS funds the required equipment and systems by a combination of allocating a portion of operating funds and obtaining external funding from charitable donations and capital grants. AHS borrows to finance capital investments related to ancillary operations since AHW does not fund ancillary operations.

AHS complied with all debt covenants during the year. In the event of default, the entire outstanding indebtedness secured by and payable to Alberta Capital Financing Authority (ACFA), at their option, becomes due and payable forthwith and without notice to AHS. ACFA may also elect to retain all or any part of the collateral in satisfaction of the indebtedness of AHS. AHS monitors and forecasts all debt covenants.

Where AHS has incurred an accumulated deficit, legislation requires submission of a deficit elimination plan (Note 16).

(n) Accounting Policy Changes

As of April 1, 2009 AHS has adopted the new CICA accounting standard Section 4470 - Disclosure of Allocated Expenses. The standard requires AHS to disclose policies adopted for the allocation of fundraising and general support expenses among functions, the nature of the expenses being allocated, the basis on which such allocations have been made, and the functions to which they have been allocated.

AHS does not allocate any fundraising costs. AHS allocates general support and other expenses to comply with the Canadian Institute of Health Information standards. The majority of these allocations are from groupings for accountability purposes to where they contribute directly to the output of one function.

In December 2006, the CICA issued Section 3862 Financial Instruments Disclosures and Section 3863 Financial Instruments Presentation which replaces Section 3861 Financial Instruments Disclosure and Presentation. As a not-for-profit organization, AHS has elected to not adopt the new standards and has continued to disclose for financial instruments under Section 3861.

Note 3 Budget

A preliminary business plan with a budgeted deficit of $885,000 was approved by the Board on June 30, 2009 and the full financial plan was submitted to the Minister of Health and Wellness on August 10, 2009. Reclassifications between revenue and expense categories were approved by the Board on December 3, 2009 and submitted to the Minister of Health and Wellness on December 10, 2009. The reported budget reflects the original $885,000 deficit and additional reclassifications required for more consistent presentation with current and prior year results (Schedule 3).

Over the course of the fiscal year, the Minister provided additional funding of $343,000 for accumulated deficit elimination and $58,700 for H1N1 response costs. The Board has allocated these additional resources to address the expectations of the funding, however the approved budget has not been changed.

Note 4 Restructure of the Health Services Delivery System in Alberta

(a) Provincial Health Authorities of Alberta operating as Health Boards of Alberta

The Provincial Health Authorities of Alberta operating as Health Boards of Alberta (HBA Services) was transferred to AHS (formerly East Central Health) on November 1, 2008. All assets and liabilities including all rights, obligations, commitments and contingencies were transferred to AHS at the carrying values. Net assets at the time of transfer were $3,116.

(b) Regional health authorities and boards

As described in Note 1, effective April 1, 2009, all business affairs, assets, liabilities, rights and obligations of the Province's former nine regional health authority boards, Alberta Mental Health Board, Alberta Cancer Board and Alberta Alcohol and Drug Abuse Commission were transferred to Alberta Health Services. The continuity of control over the business operations and net assets transferred to AHS did not change as the Government of Alberta continues to retain control over AHS. Since there was no substantive change in control, the carrying value of these items was retained by AHS upon transfer. Financial statements of AHS presented for prior periods reflect the financial position and results of operations as if AHS had always been assigned with the business affairs of the disestablished health authorities and health boards. Accordingly, balances and transactions between the disestablished health authorities were eliminated and amounts have been reclassified and adjusted to match current year presentation (Schedule 4).

Note 4 Restructure of Health Services Delivery System in Alberta (continued)

	As at March 31, 2009			For the Year Ended March 31, 2009	
	Assets	Liabilities	Net Assets	Revenue	Expenses
Eliminations	$ (68,993)	$ (68,993)	$ -	$ (169,266)	$ (169,266)
Reclassifications	(3,497)	(3,126)	(371)	8,597	8,597

(c) Ambulance services

Effective April 1, 2009, the administration and operations of emergency medical services (EMS) within the Province were transitioned to AHS. The transition was made through contracts with previous service providers, and in some cases the transfer of service operations to AHS. Also effective April 1, 2009, the contract for rotary air ambulance services by the Alberta Shock Trauma Air Rescue Society (STARS) was transitioned from AHW to AHS. Ambulance services in the Consolidated Statement of Operations includes $306,048 of expenses related to EMS and STARS. Subsequent to year end, fixed wing and other rotary air ambulance services will also be transitioned to AHS.

Note 5 Investment and Other Income

	2010	2009
Realized investment income	$ 25,480	$ 31,710
Other than temporary impairment of investments	-	(5,023)
Other income	225,427	255,995
	$ 250,907	$ 282,682

Note 6 Funded Transition Costs

AHS received $80,000 in funding from AHW for the costs of transitioning to AHS (Note 1). These costs consist of severance costs and termination benefits, professional services, consulting costs, transferring employees to LAPP, unfunded supplemental pension plan obligations and payments and other applicable transition expenses. Of the total funding, $54,365 was expensed in the Consolidated Statement of Operations (2010 - $13,804, 2009 - $40,561), $21,377 was used in 2009 to fund the supplemental pension plans, and $4,258 was capitalized in 2009 in the Consolidated Statement of Financial Position. The offsetting revenue of $13,804 (2009 - $66,196) is reported as Alberta Health and Wellness contributions.

Note 7 Funded H1N1 Costs

During the year, AHS responded to the need for providing public health awareness, vaccination and assessment clinics, and emergency and acute care for the outbreak of H1N1 influenza. AHW provided the vaccine at no cost to AHS and has funded the following costs incurred by AHS:

	2010
Inpatient acute nursing services	$ 15,295
Emergency and outpatient services	4,379
Facility-based continuing care services	511
Ambulance services	140
Diagnostic and therapeutic services	5,646
Promotion, prevention and protection services	22,619
Support services	363
Funded costs expensed in the Consolidated Statement of Operations	48,953
Inventory purchases in the Consolidated Statement of Financial Position	4,876
Capital asset purchases in the Consolidated Statement of Financial Position	4,871
Total funded H1N1 costs	$ 58,700

The offsetting revenue of $58,700 is reported as Alberta Health and Wellness contributions.

Note 8 Cash, Cash Equivalents and Investments

	2010		2009	
	Fair Market Value	Cost	Fair Market Value	Cost
Cash	$ 1,552,995	$ 1,552,995	$ 2,325,364	$ 2,325,364
Money market securities	65,101	65,095	257,182	257,186
Fixed income securities	251,528	247,374	264,945	265,813
Equities	107,206	94,123	104,051	120,916
	$ 1,976,830	$ 1,959,587	$ 2,951,542	$ 2,969,279
Classified as:				
Current				
Unrestricted	$ 313,663		$ 305,867	
Restricted	663,553		838,356	
	977,216		1,144,223	
Non-current				
Restricted	999,614		1,807,319	
Total cash, cash equivalents and investments	$ 1,976,830		$ 2,951,542	

Cash and cash equivalents consists of cash on hand, balances with banks, and investments in money market securities with original maturities of less than three months which will be used to fund AHS's activities over the next 12 months.

In order to earn optimal financial returns at an acceptable level of risk, AHS has established an investment bylaw with maximum asset mix ranges of 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities, and 0% to 40% for equities. Risk is reduced through asset class diversification, diversification within each asset class and quality constraints on fixed income securities and equity investments.

(a) Interest Rate Risk

AHS manages the interest rate risk exposure of its fixed income investments by management of average duration and laddered maturity dates.

Money market securities are comprised of Government of Canada treasury bills maturing between April 2010 and June 2010 and bear interest at an average effective yield of 0.22% per annum.

Note 8 Cash, Cash Equivalents and Investments (continued)

Fixed income securities, such as bonds, have an effective yield of 3.7% per year, maturing between 2010 and 2108. As at March 31, 2010, the securities have the following maturity structure:

1 – 5 years	42 %
6 – 10 years	30 %
Over 10 years	28 %

(b) Currency Rate Risk

AHS is exposed to foreign exchange fluctuations on its investments denominated in foreign currencies. However, this risk is limited by the fact that AHS's investment bylaw limits non-Canadian equities to 25% of total equities.

(c) Credit and Market Risks

AHS is exposed to credit risk from the potential non-payment of accounts receivable. However, the majority of the value of AHS's receivables are from AHW, therefore credit risk is considered to be minimal.

AHS's investment bylaw restricts the types and proportions of eligible investments, thus mitigating AHS's exposure to market risk. Money market securities are limited to a rating of R1 or equivalent or higher and no more than 10% may be invested in any one issuer. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total fixed income securities. Investments in debt and equity of any one issuer are limited to 5% of the issuer's total debt and equity. Short selling is not permitted.

Note 9 Capital Assets

	2010			2009
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Facilities and improvements	$ 5,087,667	$ 1,952,252	$ 3,135,415	$ 2,865,260
Work in progress	1,824,049	-	1,824,049	1,515,163
Equipment	1,561,898	1,019,678	542,220	563,110
Information systems	759,969	493,887	266,082	228,240
Leased facilities and improvements	156,652	66,076	90,576	95,832
Land	106,330	-	106,330	106,330
Building service equipment	341,765	173,077	168,688	143,729
Land improvements	63,479	45,727	17,752	21,743
	$ 9,901,809	$ 3,750,697	$ 6,151,112	$ 5,539,407

(a) Leased Land

Land at the following sites has been provided to AHS at nominal values:

Site	Leased from	Lease expiry
Alberta Children's Hospital	University of Calgary	2101
Banff Health Unit	Mineral Springs Hospital	2028
Cross Cancer Institute parkade	University of Alberta	2019
Foothills Medical Centre parkade	University of Calgary	2054
McConnell Place North	City of Edmonton	2035
Northeast Community Health Centre	City of Edmonton	2048

(b) Leased Equipment

Equipment includes assets acquired through capital leases at a cost of $11,283 (2009 - $11,302) with accumulated amortization of $10,415 (2009 - $11,057).

(c) Capital Asset Write-Down

During the year AHS discontinued operations of the Raymond Care Centre and Picture Butte Municipal Hospital, and recorded a write-down of $2,682 to reduce the facilities' carrying value to their fair market value. During the prior year, AHS discontinued development of a human resources information system and recorded a write-down of $13,810 to reduce the carrying value to $nil.

Note 9 Capital Assets (continued)

(d) Option to Purchase Hospital

AHS owns the land and buildings of the Grey Nuns Community Hospital and has contracted Covenant Health to operate it. Covenant Health has an option to purchase the land and buildings of the Grey Nuns Community Hospital at market value subject to consent from the Minister of Health and Wellness.

Note 10 Other Assets

	2010	2009
Long-term care partnerships – demand loans (Note 11 (a))	$ 93,904	$ 81,581
Contributions receivable	20,514	50,690
Other non-current assets	13,195	12,515
	$ 127,613	$ 144,786

Note 11 Deferred Contributions

Deferred contributions represent unspent externally restricted resources. Changes in the deferred contributions balance are as follows:

	2010			2009
	AHW	Others	Total	Total
Balance beginning of the year	$ 517,547	$ 294,419	$ 811,966	$ 679,706
Amount received during the year	737,151	155,035	892,186	1,100,331
Amount transferred from (to) deferred capital contributions	(6,280)	1,805	(4,475)	93,553
Interest earned	1,831	1,333	3,164	5,007
Amount recognized as revenue	(827,157)	(144,707)	(971,864)	(1,066,631)
Balance at end of the year	$ 423,092	$ 307,885	$ 730,977	$ 811,966

Note 11 Deferred Contributions (continued)

The balance at the end of the year is restricted for the following purposes:

	2010			2009
	AHW	Others	Total	Total
Current:				
Mental health and Safe Communities	$ 128,572	$ 1,329	$ 129,901	$ 127,427
Research and education	3,604	69,675	73,279	63,994
Cancer prevention and research	36,270	15,410	51,680	43,911
Infrastructure maintenance	45,930	618	46,548	74,266
Primary Care Networks	41,826	-	41,826	39,194
Physician revenue and Alternate Relationship Plans	37,380	1,804	39,184	41,836
Promotion, prevention and community	18,428	16,372	34,800	48,371
Continuing care and seniors health	22,698	3,480	26,178	26,874
EMS transition	18,318	-	18,318	33,312
Diagnostic and therapeutic services	12,515	3,102	15,617	11,103
Emergency and outpatient services	6,243	7,606	13,849	17,377
Healthy Workforce Action Plan	785	10,343	11,128	10,470
Information technology	10,476	610	11,086	9,987
Inpatient acute nursing services	5,326	4,763	10,089	17,738
Wait times	9,898	-	9,898	13,129
Pandemic	8,613	-	8,613	10,801
Regional Shared Health Information Program	8,090	-	8,090	10,273
Telehealth	7,383	39	7,422	9,009
Support services	637	3,535	4,172	3,656
Student health initiatives	-	547	547	498
AHS transition	-	-	-	13,804
Other	100	5,402	5,502	3,590
	423,092	144,635	567,727	630,620
Non-current:				
Long term care partnerships [a]	-	157,435	157,435	171,750
Other	-	5,815	5,815	9,596
	-	163,250	163,250	181,346
	$ 423,092	$ 307,885	$ 730,977	$ 811,966

Note 11 Deferred Contributions (continued)

(a) Long-term care partnership agreements

AHS has entered into partnership with private and voluntary health service providers to build and operate long-term care facilities within the Province. The Government of Alberta has supported these partnerships through providing one-time, upfront capital funding to enable AHS and the voluntary and private partners to develop the approved infrastructure. Two partnership models have been used for the payment of the grant from AHS to the partnership organizations; the Supplementary Payment Model and the Modified Mortgage Model.

Under the Supplementary Payment Model, AHS makes annual payments to the partner over the term of the partnership contract, which is usually the expected useful life of the infrastructure. Amounts invested under the terms of long-term care partnership agreements will be utilized to fund future payments to providers over the next 23 years. These payments have a net present value of $26,067 at March 31, 2010 (2009 - $28,457) discounted at 3.0% (2009 – 2.5%). The cash, cash equivalents and investments have a market value at March 31, 2010 of $37,020 (2009 - $32,223). AHS is subject to risk to meet the payment obligations as they become due.

AHS recognizes the supplementary payment expenses in facility-based continuing care services on the Consolidated Statement of Operations and recognizes an equal amount of revenue as other government contributions through the amortization of deferred contributions long-term care partnership projects. Investment income earned, net of management fees, is recorded as an increase to both the investment base and the deferred contribution.

Under the Modified Mortgage Model, AHS provides a demand loan to the partner who uses the funds to construct the infrastructure. The loan is forgivable over the useful life of the infrastructure. The loan is repayable on demand, is secured by the facility and is forgivable for services rendered by the owner over the life of the facility. AHS does not accrue interest on the loan as AHS intends to forgive the balance of the loan following the expiry of the term of the agreement.

AHS amortizes the long-term care partnership project demand loans (Note 10) to facility-based continuing care services on the Consolidated Statement of Operations and recognizes an equal amount of revenue as other government contributions through the amortization of deferred contributions long-term care partnership projects.

Note 12 Deferred Capital Contributions

Deferred capital contributions represent unspent externally restricted resources related to capital assets. Changes in the deferred capital contributions balance are as follows:

	2010			2009
	AHW	Others	Total	Total
Balance beginning of the year	$ 1,607,113	$ 89,663	$ 1,696,776	$ 1,778,304
Amount received during the year	207,544	28,913	236,457	926,463
Amount transferred to unamortized external capital contributions	(827,552)	(63,596)	(891,148)	(915,094)
Amounts transferred from (to) deferred contributions	6,280	(1,805)	4,475	(93,553)
Interest earned	271	1	272	656
Other	358	(1,050)	(692)	-
Balance at end of the year	$ 994,014	$ 52,126	$ 1,046,140	$ 1,696,776

The balance at the end of the year is restricted for the following purposes:

	2010			2009
	AHW	Others	Total	Total
Facilities and improvements:				
Infrastructure maintenance projects	$ 158,031	$ -	$ 158,031	$ 96,275
Calgary South Health Campus	93,548	-	93,548	316,994
The Edmonton Clinic	102,731	-	102,731	199,472
Capital escalation	63,658	-	63,658	63,658
Rockyview General Hospital	35,909	-	35,909	62,861
Peter Lougheed Centre	22,045	-	22,045	55,080
Foothills Medical Centre	18,702	-	18,702	100,060
Royal Alexandra Hospital – New North Treatment Tower	26,653	7,055	33,708	52,049
Other less than $50,000	258,000	13,850	271,850	457,996
	779,277	20,905	800,182	1,404,445
Information systems	159,989	6,719	166,708	221,435
Equipment	54,748	24,502	79,250	70,896
	$ 994,014	$ 52,126	$ 1,046,140	$ 1,696,776

Note 13 Long-term Debt

	2010	2009
Debentures payable: (i)		
Parkade loan #1	$ 48,747	$ 50,722
Parkade loan #2	44,020	45,664
Parkade loan #3	53,332	55,000
Parkade loan #4	5,000	-
Calgary Laboratory Services purchase	22,697	28,535
Term loan (ii)	83,000	-
Mortgages payable	-	2,022
Obligation under capital lease (iii)	16,042	15,955
Other	2,866	3,386
	$ 275,704	$ 201,284
Current	$ 12,938	$ 12,068
Non-current	262,766	189,216
	$ 275,704	$ 201,284
Fair value of total long-term debt (iv)	$ 282,242	$ 209,945

(i) AHS issued debentures to Alberta Capital Financing Authority (ACFA), a related party, to finance the construction of parkades and the purchase of the remaining 50.01% ownership interest in CLS. AHS has pledged as security for these debentures revenues derived directly or indirectly from the operations of all parking facilities being built, renovated, owned and operated by AHS.

As at March 31, 2010, $5,000 of $181,000 has been advanced to AHS relating to the Parkade loan #4 debenture with the remaining to be drawn by September 1, 2011. Semi-annual principal and interest payments of $7,165 will commence March 1, 2012.

The maturity dates and interest rates for the debentures are as follows:

	Maturity Date	Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Calgary Laboratory Services purchase	May 2013	4.6810%

Note 13 Long-term Debt (continued)

(ii) AHS has obtained a term loan facility of $181,000 during 2010, of which $83,000 has been drawn at March 31, 2010. The facility has been secured by the issuance of the Parkade #4 debenture to ACFA. Although the loan is repayable on demand, repayment terms are for monthly payment of interest only at 2.755%, with the full principal repayment due upon maturity on September 1, 2011. Management does not believe that the demand features of the callable debt will be exercised in the current period.

(iii) The capital lease expires January 2028. The implicit interest rate payable on this lease is 6.5%.

(iv) The fair value of long-term debt is estimated based on market interest rates from ACFA for debentures of similar maturity.

(v) As at March 31, 2010 AHS held a $220,000 revolving demand facility with a Canadian chartered bank which may be used for operating purposes. Draws on the facility bear interest at the bank's prime rate less 0.5% per annum. As at March 31, 2010, AHS has no draws against this facility.

AHS also holds a $40,000 revolving demand letter of credit facility which may be used to secure AHS's obligations to third parties relating to construction projects. As at March 31, 2010, AHS had $4,305 in letters of credit outstanding against this facility.

AHS is committed to making payments as follows:

Year ended March 31	Debentures Payable, Term/Other Loan and Mortgages Payable Principal payments	Capital Lease Minimum lease payments
2011	$ 11,852	$ 1,716
2012	98,113	1,659
2013	15,277	1,465
2014	10,040	1,453
2015	6,870	1,453
Thereafter	117,510	19,752
	$ 259,662	27,498
Less: interest		11,456
		$ 16,042

During the year, the amount of interest expense was $8,845 (2009 - $7,091).

Note 14 Other Liabilities

Other liabilities are made up of the following balances:

		2010		2009
Asset retirement obligations [(a)]	$	10,713	$	13,029
Life lease deposits [(b)]		12,603		13,625
Supplemental pension plans accrued benefit (asset) liability [(c)]		(6,180)		14,491
Other		1,295		4,279
	$	18,431	$	45,424

(a) Asset Retirement Obligations

The asset retirement obligation (ARO) represents the legal obligation associated with the removal of asbestos during planned renovations of AHS buildings. The total undiscounted amount of the estimated cash flows required to settle the recorded obligation is $11,474 (2009 - $13,767), which has been discounted using a weighted average credit-adjusted risk free rate of 2.1% (2009 - 4.2%). Payments to settle the ARO are expected to occur by 2014. AHS has identified the existence of asbestos in other buildings which is not required to be remediated at this time and therefore is not recorded as an obligation.

(b) Life Lease Deposits

Funding for the Laurier House facilities, a project for long-term care residents in Edmonton, is provided by the tenants with a non-interest bearing repayment deposit, for the right to occupy the unit they are leasing. When the life lease agreement is terminated, which may be by death of the tenant or the tenant moving out, the life lease deposit is returned to the tenant without interest and in accordance with the terms of the Life Lease Agreement. The liability for life lease deposits is based on a discharge rate of 25% and a discount rate of 2.0%, representing the bank secured lending rate. The reported liability is based on estimates and assumptions with respect to events extending over a 4 year period using the best information available to management.

Note 14 Other Liabilities

(c) Supplemental Pension Plans

As of April 1, 2009 there were seven SPPs sponsored by AHS. These plans were either funded, secured by letters of credit, or unfunded. Each plan was closed to new entrants effective April 1, 2009 and during the ensuing fiscal year, the SPPs were consolidated into three funded SPPs. Under the terms of the three SPPs, participants will receive retirement benefits that supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). As required under the plans' terms, any unfunded obligations identified in the actuarial valuation completed at the end of each fiscal year must be fully funded within 61 days. The accounting policies for SPPs are described in Note (2 (i)).

	2010	2009		
	Total Plans with a surplus	Plans with a surplus	Plans with a deficit	Total
Change in accrued benefit obligation				
Accrued benefit obligation, beginning of year	$ 28, 715	$ 8,565	$ 22,294	$ 30,859
Accrued benefit obligation, Nov 1, 2009 (HBA Services)	-	491	-	491
Service cost	1,701	748	1,809	2,557
Interest cost	2,000	465	1,249	1,714
Past service cost	-	-	187	187
Benefit payments	(3,224)	(1,229)	(2,736)	(3,965)
Actuarial losses (gains)	2,617	(1,113)	(2,015)	(3,128)
Accrued benefit obligation, end of year	$ 31,809	$ 7,927	$ 20,788	$ 28,715
Change in plan assets				
Fair value of plan assets, beginning of year	$ 10,178	$ 7,427	$ 981	$ 8,408
Fair value of plan assets, Nov 1, 2009 (HBA Services)	-	711	-	711
Adjustment to opening value	-	3	-	3
Actual return on plan assets	510	(314)	-	(314)
Actual employer contributions	24,903	2,433	2,948	5,381
Actual plan expenses	-	-	(46)	(46)
Benefit payments	(3,224)	(1,229)	(2,736)	(3,965)
Fair value of plan assets, end of year	$ 32,367	$ 9,031	$ 1,147	$ 10,178
Reconciliation of funded status to accrued benefit asset/liability				
Funded status of the plan	$ 558	$ 1,104	$ (19,641)	$ (18,537)
Unrecognized net actuarial losses	4,334	463	1,626	2,089
Unrecognized initial obligations	512	559	219	778
Unrecognized past service cost	776	334	845	1,179
Accrued benefit asset (liability), end of year	$ 6,180	$ 2,460	$ (16,951)	$ (14,491)

Note 14 Other Liabilities (continued)

	2010	2009		
	Total Plans with a surplus	Plans with a surplus	Plans with a deficit	Total
Determination of net benefit cost				
Service cost	$ 1,701	$ 748	$ 1,809	$ 2,557
Interest cost	2,000	465	1,249	1,714
Actual return on assets	(510)	314	-	314
Actual prior service cost in year	-	-	187	187
Actuarial losses (gains) in year	2,617	(1,117)	(2,015)	(3,132)
Amortization of initial obligations	264	641	128	769
Difference between expected and actual return on assets	224	(536)	-	(536)
Difference between recognized and actual actuarial gains/losses	(2,468)	1,573	2,921	4,494
Difference between recognized and actual past service costs	405	112	359	471
Net benefit cost	$ 4,233	$ 2,200	$ 4,638	$ 6,838
Members				
Active	64			80
Retired and terminated	55			51
Total members	119			131
Assumptions				
Weighted average discount rate to determine year end obligations	5.40%	6.20%	6.56%	6.46%
Weighted average discount rate to determine net benefit costs	6.38%	5.17%	5.33%	5.28%
Expected return on assets	2.70%	3.10%	0.00%	0.86%
Expected average remaining service life time	5	8	6	6
Rate of compensation increase	Note (i)	4.00%	4.33%	4.28%

(i) 1.5% per year for 2010 – 2011
3.2% per year for 2012 – 2014
3.5% per year thereafter

Note 15 Pension Expense

		2010		2009
Registered benefit plans [(a)]	$	300,513	$	249,614
Costs to transfer employees to LAPP		33,000		7,000
Defined contribution pension plans		11,326		9,808
Supplemental Pension Plans		4,233		6,838
	$	349,072	$	273,260

(a) Registered Benefit Plans

AHS participates in the Local Authorities Pension Plan (LAPP) and the Management Employee Pension Plan (MEPP), which are multi-employer defined benefit plans. The pension expense recorded in these consolidated financial statements is equivalent to AHS's contributions to the plan during the year as determined by LAPP and MEPP. At December 31, 2009 LAPP reported a deficiency of $3,998,614 (2008 - deficiency of $4,413,971), and MEPP reported a deficiency of $483,199 (2008 – $568,574).

Note 16 Accumulated Surplus/(Deficit)

AHS reported an accumulated deficit at March 31, 2010. Per Alberta Regulation 15/95 of the *Regional Health Authorities Act* (Alberta), AHS will provide the Minister with a plan in writing to eliminate the accumulated deficit within three years of incurrence.

The Province announced on February 9, 2010 that it would fund AHS's accumulated deficit as at March 31, 2010.

Note 17 Endowments

		2010		2009
Alberta Cancer Research Institute Director Research Chair [(a)]	$	10,000	$	10,000
J.K. Bigelow Education Fund [(b)]		150		150
	$	10,150	$	10,150

(a) The Alberta Cancer Research Institute (ACRI) Director Research Chair endowment is internally restricted and is designated for use as a Research Chair for the Director of ACRI. The principal amount of $10,000 is required to be maintained and all investment proceeds are available for use. Investment proceeds from the fund are recorded as a deferred contribution until used for the salary, infrastructure and operating grant support for the ACRI Director Research Chair.

Note 17 Endowments (continued)

(b) The J.K. Bigelow Education Fund endowment is internally restricted and is designated for funding of health related courses undertaken by employees of AHS in the Lethbridge area. The principal amount of $150 is required to be maintained and all investment proceeds are available for use. Investment proceeds are recorded as deferred contributions until used for education.

Note 18 Commitments and Contingencies

(a) Leases

AHS is contractually committed to future operating lease payments for premises until 2029 as follows:

Year ending March 31		
2011	$	43,799
2012		40,412
2013		35,070
2014		25,986
2015		21,441
Thereafter		63,736
	$	230,444

(b) Capital Assets

AHS has the following outstanding contractual commitments for capital assets as of March 31:

		2010
Facilities and improvements	$	1,595,077
Information systems		28,340
Equipment		48,974
	$	1,672,391

(c) Contracted Health Service Providers

AHS contracts on an ongoing basis with voluntary and private health service providers to provide health services in the Province as disclosed in Note 19 (d). AHS has contracted for services in the year ending March 31, 2011 similar to those provided by these providers in 2010.

Note 18 Commitments and Contingencies (continued)

(d) Contingencies

AHS has been named as a defendant in a legal action in respect of increased long-term care accommodation charges levied effective August 1, 2003. The claim has been filed against the Government of Alberta and the former Regional Health Authorities (now AHS). The amount of the claim has not been specified but has been estimated to be between $100 million and $175 million per year based on the amount of the increase in accommodation charges levied, which came into effect August 1, 2003. The outcome of the claim is not determinable and no liability is recorded at this time.

AHS has a contingent liability in respect of claims relating to the failure of St. Joseph's Hospital to provide adequate infection control and safety measures to prevent contamination of medical equipment. The total amount of these claims is in excess of $25 million. The outcome of the claims is not determinable, and no liability is recorded at this time.

As at March 31, 2010 AHS is named as a defendant in 379 legal claims (2009 – 356 legal claims). 329 of these claims have specified amounts totaling $1,306,699 and the remaining 50 have no specified amount. Included in the total legal claims are 7 claims amounting to $93,965 in which AHS has been jointly named with other entities. 345 claims amounting to $1,283,095 are covered by the Liability and Property Insurance Plan subject to the limits described in Note 19(f). The resulting loss, if any, from these claims cannot be determined, and therefore no liability is recorded at this time.

Note 19 Related Parties

Transactions with the following related parties are considered to be in the normal course of operations. Amounts due to or from the related parties and the recorded amounts of the transactions are included within these consolidated financial statements, unless otherwise stated.

(a) Government of Alberta

The Minister of Health and Wellness appoints the AHS Board members. Transactions between AHS and AHW are reported and disclosed in the Consolidated Statement of Operations, the Consolidated Statement of Financial Position, and the Notes to the Consolidated Financial Statements.

AHS shares a common relationship and is considered to be a related party with other ministries through its relationship with the Government of Alberta. Transactions in the normal course of operations between AHS and the other ministries are recorded at their exchange amount as follows:

Note 19 Related Parties (continued)

	Revenue		Expenses	
	2010	2009	2010	2009
Ministry of Advanced Education	$ 24,098	$ 30,839	$ 110,804	$ 110,344
Other Ministries	11,863	11,057	13,575	12,748
Total for the year	$ 35,961	$ 41,896	$ 124,379	$ 123,092

	Receivable from		Payable to	
	2010	2009	2010	2009
Ministry of Advanced Education	$ 2,662	$ 147	$ 10,646	$ 12,734
Other Ministries	1,863	2,550	49	4,669
Balance at end of the year	$ 4,525	$ 2,697	$ 10,695	$ 17,403

Most of AHS transactions with the Ministry of Advanced Education relate to initiatives with the University of Alberta and the University of Calgary. These initiatives include teaching, research, and program delivery. A number of physicians are employed by either AHS or the universities but perform services for both. Due to proximity of locations, some initiatives result in sharing physical space and support services. The revenue and expense transactions are a result of grants provided from one to the other and recoveries of shared costs.

(b) Primary Care Networks

AHS has joint control with various physician groups over Primary Care Networks (PCN). AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services, to achieve the PCN business plan objectives, and to contract and hold property interests required in the delivery of PCN services. Both parties have equal share ownership and equal Board representation. The following PCNs are included in these consolidated financial statements under the proportionate consolidation method:

Note 19 Related Parties (continued)

Alberta Heartland Primary Care Network
Big Country Primary Care Network
Bonnyville / Aspen Primary Care Network
Bow Valley Primary Care Network
Calgary Foothills Primary Care Network
Calgary Rural Primary Care Network
Calgary West Central Primary Care Network
Camrose Local Primary Care Initiative
Chinook Primary Care Network
Edmonton North Primary Care Network
Edmonton Oliver Primary Care Network
Edmonton Southside Primary Care Network
Edmonton West Primary Care Network
Highland Primary Care Network
Leduc Beaumont Devon Primary Care Network
MacLeod River Primary Care Network
Mosaic Primary Care Network
Northwest Primary Care Network
Palliser Primary Care Network
Peace River Primary Care Network
Provost – Consort Primary Care Network
Red Deer Primary Care Network
Rocky Mountain House Primary Care Network
Sexsmith Primary Care Network
Sherwood Park Primary Care Network
South Calgary Primary Care Network
St. Albert and Sturgeon Primary Care Network
St. Paul / Aspen Primary Care Network
West Peace Primary Care Network
Westview Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

AHS's proportionate share of AHW's contribution to PCNs are as follows:

	2010	2009
Opening balance of deferred contributions	$ 39,194	$ 37,135
Contributions from AHW	56,788	41,932
Contributions recognized as revenue	(54,156)	(39,873)
Closing balance of deferred contributions	$ 41,826	$ 39,194

Note 19 Related Parties (continued)

(c) Foundations

A large number of foundations provide donations of money and services to AHS to enhance health care in various communities throughout the Province. This financial support to AHS is reflected in donations revenue and capital contributions. These foundations are registered charities under the Income Tax Act (Canada) and accordingly, are exempt from income taxes, provided certain requirements of the Income Tax Act are met.

(i) Controlled foundations

A number of foundations are considered to be controlled entities as AHS appoints all trustees for such foundations. Controlled foundations are not consolidated in these financial statements.

The Alberta Cancer Foundation (ACF) and the Calgary Health Trust (CHT) are the most significant controlled foundations. The following aggregated financial information of ACF and CHT is presented using the same accounting policies as AHS:

	2010		2009	
	ACF	CHT	ACF	CHT
Revenue	$ 27,263	$ 59,456	$ 20,130	$ 51,530
Expenses	29,420	58,146	21,505	50,518
Excess (deficiency) of revenue over expenses	$ (2,157)	$ 1,310	$ (1,375)	$ 1,012
Total assets	$ 95,634	$ 88,448	$ 81,087	$ 95,675
Total liabilities	28,835	68,670	23,776	80,886
Net assets	$ 66,799	$ 19,778	$ 57,311	$ 14,789

Note 19 Related Parties (continued)

Financial information for the remaining controlled foundations is not disclosed because AHS does not receive financial information from all these foundations on a timely basis and the cost and effort of preparing financial information for disclosure exceeds the benefit of doing so. These foundations are immaterial organizations individually and in aggregate relative to AHS. The following are the remaining foundations controlled by AHS as at March 31, 2010:

Alberta Hospital Edmonton and Community Mental Health Foundation
Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Canmore and Area Health Care Foundation
Capital Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Trust
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grand Cache Hospital Foundation
Grimshaw/Berwyn Hospital Foundation
Jasper Health Care Foundation
Medicine Hat and District Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Viking Health Foundation
Windy Slopes Health Foundation

Note 19 Related Parties (continued)

The following foundations are also considered controlled, but are in the process of being wound-up or are considered to be inactive:

Central Peace Hospital Foundation
Peace Health Region Foundation
Manning Community Health Centre Foundation
McLennan Community Health Care Foundation
Lakeland Regional Health Authority Foundation

(ii) Other foundations

AHS has an economic interest in a number of foundations as they raise and hold resources to support AHS. AHS appoints one board trustee for such foundations. Financial information for these foundations is not disclosed because AHS does not receive financial information from all these foundations on a consistent and timely basis and the cost and effort of preparing financial information for disclosure exceeds the benefit of doing so. The following are the foundations that AHS has an economic interest in as of March 31, 2010:

Alberta Children's Hospital Foundation
Beaverlodge Hospital Foundation
Black Gold Health Foundation
Chinook Regional Hospital Foundation
Consort Hospital Foundation
Coronation Heath Centre Foundation
Daysland Hospital Foundation
Devon General Hospital Foundation
Drayton Valley Health Services Foundation
Drumheller Area Health Foundation
Fairview Health Complex Foundation
Glenrose Rehabilitation Hospital Foundation
High River District Health Care Foundation
Hinton Health Care Foundation
Hythe Nursing Home Foundation
Northern Lights Regional Health Foundation
Northwest Health Foundation
Queen Elizabeth II Hospital Foundation
Rosebud Health Foundation
Royal Alexandra Hospital Foundation
Sheep River Health Trust
St. Paul and District Hospital Foundation
Stettler Health Services Foundation
Stollery Children's Hospital Foundation
Strathmore District Health Foundation
Sturgeon Community Hospital Foundation
Taber and District Health Foundation
Tri-Community Health and Wellness Foundation
University Hospital Foundation
Valleyview Health Centre Foundation
Wainwright and District Community Foundation
Wetaskiwin Health Foundation

Note 19 Related Parties (continued)

(d) Contracts with Health Service Providers

AHS is responsible for the delivery of health services in the Province. To this end, AHS contracts with various private and voluntary health service providers to continue to provide health services throughout the Province. The largest of these service providers is Covenant Health; the total amount funded to Covenant Health during the year was $551,098 (2009 - $503,678). As of March 31, 2010, the net book value of assets owned by AHS but operated by a voluntary or private health service provider was $141,844 (2009 - $141,374).

AHS has an economic interest through its contracts with certain voluntary and private health service providers as AHS transfers significant resources as follows:

	2010			2009		
	Voluntary Health Service Providers	Private Health Service Providers	Total	Voluntary Health Service Providers	Private Health Service Providers	Total
Direct AHS funding	$816,197	$778,183	$1,594,380	$793,723	$649,703	$1,443,426
Direct AHW funding	-	986	986	-	1,219	1,219
Fees and charges	95,490	94,284	189,774	94,884	86,552	181,436
Full cost adjustments	14,387	83	14,470	14,288	82	14,370
Total	$926,074	$873,536	$1,799,610	$902,895	$737,556	$1,640,451

(e) Health Organizations Benefit Plan

AHS is a participant in the Health Organizations Benefit Plan (HOBP) which is a formal health and welfare trust established under a Trust Agreement effective January 1, 2000. HOBP provides health and other related employee benefits pursuant to the authorizing Trust Agreement. HOBP uses various carriers for the different benefits. As a trust, HOBP is exempt from the payment of income taxes.

AHS is one of more than thirty participants in HOBP and has the majority of representation on HOBP's governance board. It is recognized that as individuals and as the HOBP board collectively, the board has a fiduciary duty to act in the best interest of all participants and HOBP itself.

Under the terms of the Trust Agreement, no participating employer or eligible employee shall have any right to any surplus or assets of the Trust nor shall they be responsible for any deficits or liabilities of the Trust. HOBP maintains various reserves to adequately provide for all current obligations, and reported fund balances of $29,594 as at December 31, 2009 ($19,339 as at December 31, 2008). AHS paid premiums of $38,159 (2009 - $30,663).

Note 19 Related Parties (continued)

(f) Liability and Property Insurance Plan

AHS is a subscriber to the Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP) which is a reciprocal insurance exchange duly established under the *Insurance Act* (Alberta). The main purpose of LPIP is to share the risks of liability to lessen the impact on any one subscriber. LPIP is administered pursuant to the terms and conditions of the Reciprocal Insurance Exchange Agreement to which all subscribers are signatories. As a reciprocal LPIP is exempt from the payment of income tax but is subject to the provincial premium tax.

LPIP provides its subscribers with general and professional liability coverage and insures some of its subscriber's buildings and contents. AHS claims are subject to a maximum limit of $5 million per occurrence with an additional $5 million limit per occurrence. The additional limit is subject to an absolute limit of $15 million in aggregate for all occurrences for each policy year. Claims in excess of these limits are the responsibility of AHS as the subscriber. Neither AHS nor LPIP purchase any reinsurance.

Under the terms of the agreement, in the event that LPIP has accumulated funds in excess of those required to meet its obligations, those funds may be invested to accrue to the benefit of LPIP, provided in the form of a cash dividend to its subscribers, or applied to reduce premiums to LPIP in any subsequent underwriting year. As per the Insurance Act, LPIP maintains a reserve fund and a guarantee fund. If there are insufficient funds, LPIP will collect such additional assessments from its subscribers as required.

The most recent financial results of LPIP are as follows:

	December 31, 2009	December 31, 2008
Total assets	$ 87,468	$ 75,959
Total liabilities	73,605	61,534
Net assets	$ 13,863	$ 14,425
Revenues	$ 12,332	$ 11,950
Expenses	19,714	15,439
Underwriting loss	(7,382)	(3,489)
Investment income/(loss)	6,820	(1,249)
Net loss	$ (562)	$ (4,738)

Included in liabilities is an actuarial provision for losses of $68,865 (2008 - $58,193). $51,275 (2008 – $44,892) of this provision is for liabilities incurred but not reported. Included in revenues are premiums paid by AHS of $9,746 (2008 - $9,461).

Note 19 Related Parties (continued)

AHS is one of more than fifty subscribers to LPIP and has the majority of representation on LPIP's governance board. It is recognized that as individuals and as the LPIP board collectively, the board has a fiduciary duty to act in the best interest of all subscribers and LPIP itself.

Note 20 Trust Funds

AHS receives funds in trust from AHW that are to be paid to operators of non-owned facilities for capital purposes or facility repairs, and for specific projects. In addition, AHS receives funds in trust for research and development, education and other programs. AHS receives funds in trust from AHW for some Primary Care Networks; AHS uses these funds to cover the Primary Care Networks' expenditures until they make their own banking arrangements. These amounts are not reported in these consolidated financial statements. As at March 31, 2010, the balance of funds held by AHS is as follows:

	2010	2009
AHW	$ 694	$ 12,723
Research and development, education and other programs	6,558	7,081
Primary Care Networks	3,943	3,159
	$ 11,195	$ 22,963

AHS also receives funds in trust from continuing care residents for personal expenses. These amounts are not included above and not reflected in these consolidated financial statements.

Note 21 Approval of Consolidated Financial Statements

The consolidated financial statements have been approved by the Alberta Health Services Board.

CONSOLIDATED SCHEDULE OF EXPENSES BY OBJECT FOR THE YEAR ENDED MARCH 31, 2010

	2010		2009
	Budget (Note 3)	Actual	Actual (Note 4 (b))
Salaries and benefits (Schedule 2)	$ 5,493,130	$ 5,483,260	$ 5,021,985
Contracts with health service providers (Note 19 (d))	1,716,568	1,799,610	1,640,451
Contracts under the Health Care Protection Act	23,855	23,866	22,125
Drugs and gases	334,595	332,600	317,163
Medical and surgical supplies	336,491	320,135	321,173
Other contracted services	1,148,410	1,101,908	921,762
Other *	1,195,176	1,004,079	1,069,552
Amortization:			
Equipment – internally funded	81,265	81,985	80,670
Equipment – externally funded	149,405	169,909	153,509
Facilities and improvements – internally funded	14,354	24,474	18,995
Facilities and improvements – externally funded	144,531	132,171	148,826
Loss on disposal of assets	15,081	364	11,841
Capital assets write down (Note 9 (c))	-	2,682	13,810
	$10,652,861	$ 10,477,043	$ 9,741,862
* Significant amounts included in Other are:			
Other clinical supplies	$ 114,666	$ 119,717	$ 116,380
Utilities	120,994	94,622	113,345
Equipment and software maintenance	101,312	94,429	91,131
Minor equipment purchases	43,578	73,139	66,141
Rent	69,849	72,815	59,099
Food supplies	70,126	68,397	69,796
Travel	94,778	66,066	104,553

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2010

	2010								2009	
						Severance (e)				
	Number of FTE's (a)	Base Salary (b)	Other Cash Benefits (c)	Non-Cash Benefits (d)(f)	Subtotal	Number of Individuals	Amount	Total	FTE's (a)	Total
Board Chair										
Ken Hughes	1.00	$ -	$ 104	$ -	$ 104	-	$-	$ 104	0.88	$ 77
Board Members										
Jack Ady	1.00	-	62	-	62	-	-	62	0.88	49
Lori Andreachuk	1.00	-	61	-	61	-	-	61	0.33	20
Gord Bontje	1.00	-	60	-	60	-	-	60	0.33	22
Teri Lynn Bougie	1.00	-	61	-	61	-	-	61	0.33	20
Jim Clifford	1.00	-	61	-	61	-	-	61	0.33	23
Strater Crowfoot	1.00	-	59	-	59	-	-	59	0.33	22
Tony Franceschini	1.00	-	58	-	58	-	-	58	0.33	20
Linda Hohol	1.00	-	59	-	59	-	-	59	0.88	48
Andreas Laupacis	1.00	-	60	-	60	-	-	60	0.33	20
John Lehners	1.00	-	65	-	65	-	-	65	0.88	49
Irene Lewis	1.00	-	60	-	60	-	-	60	0.88	49
Catherine Roozen	1.00	-	53	-	53	-	-	53	0.63	27
Don Sieben	1.00	-	75	-	75	-	-	75	0.88	51
Gord Winkel	1.00	-	-	-	-	-	-	-	0.33	-
Pierre Crevolin	-	-	-	-	-	-	-	-	0.21	10
Board members of former health authorities and boards	-	-	-	-	-	-	-	-	14.84	482
Total Board	15.00	$ -	$ 898	$ -	$ 898	-	$ -	$ 898	23.60	$ 989

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2010

	2010								2009	
						Severance (e)				
	Number of FTE's (a)	Base Salary (b)	Other Cash Benefits (c)	Other Non-Cash Benefits (d)(f)	Subtotal	Number of Individuals	Amount	Total	Number of FTE's (a)	Total
Board Direct Reports										
President and Chief Executive Officer (g)(h)(aa)	1.00	$ 595	$139	$ 10	$ 744	-	$ -	$ 744	0.02	$ 116
Interim Chief Executive Officer	-	-	-	-	-	-	-	-	0.88	481
Interim VP Internal Audit and Enterprise Risk Management – Contracted Services	0.09	42	-	-	42	-	-	42	-	-
VP Internal Audit and Enterprise Risk Management (n)(bb)	0.52	121	31	52	204	1.00	362	566	0.85	280
VP Internal Audit and Enterprise Risk Management (o)	0.42	81	6	17	104	-	-	104	-	-
Ethics and Compliance Officer (gg)	0.98	216	2	31	249	-	-	249	-	-
Board direct reports of former health authorities and boards	-	-	-	-	-	-	-	-	13.28	15,258
CEO Direct Reports										
Executive VP and Chief Financial Officer (h)(s)(bb)	0.97	372	89	31	492	-	-	492	-	-
Executive VP, Corporate Services (h)(q)(bb)	0.74	289	81	23	393	-	-	393	-	-
Acting Executive VP, Corporate Services (p)(q)	0.33	65	-	16	81	-	-	81	0.33	91
Executive VP, Quality and Service Improvement (h)(j)(l)(r)(cc)	1.00	486	111	215	812	-	-	812	1.00	825
Executive VP, Rural, Public and Community Health (i)(w)(dd)	1.00	374	60	87	521	-	-	521	1.00	717
Executive VP, Strategy and Performance (h)(t)(bb)	0.41	158	67	21	246	-	-	246	-	-
Acting Executive VP, Strategy and Performance (h)(j)(u)(hh)	0.75	257	102	62	421	1.00	61	482	1.00	978
Senior VP, Clinical Support Services (i)(v)(ee)	1.00	329	47	50	426	-	-	426	1.00	390
Senior Physician Executive (j)(m)(ff)	1.00	499	86	141	726	-	-	726	1.00	700
VP Community Engagement and Chief of Staff, Board Office (k)(x)(gg)	0.37	57	12	9	78	-	-	78	-	-
Chief of Staff, Board Office (y)(hh)	0.58	112	33	34	179	-	-	179	-	-
Interim Chief Operating Officer, Health Strategies, Research and Design (z)(hh)	0.08	29	14	46	89	-	-	89	1.00	745
Interim Chief Operating Officer, Corporate Services	-	-	-	-	-	-	-	-	0.45	187
Executive Operating Officer, Continuum of Care	-	-	-	-	-	-	-	-	0.71	1,861
Interim Chief Financial Officer	-	-	-	-	-	-	-	-	1.00	1,854
CEO direct reports of former health authorities and boards	-	-	-	-	-	-	-	-	58.25	21,398
Total Executive	11.24	$4,082	$ 880	$ 845	$ 5,807	2.00	$ 423	$ 6,230	81.77	$ 45,881

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2010

	2010								2009	
						Severance [e]				
	Number of FTE's [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d][f]	Subtotal	Number of Individuals	Amount	Total	Number of FTE's [a]	Total
Management reporting to CEO direct reports	42.78	$ 8,987	$ 698	$ 1,006	$ 10,691	3.00	$ 495	$ 11,186	1,613.10	$ 199,311
Other management	3,472.32	341,622	18,897	70,959	431,478	233.00	23,601	455,079	2,000.00	229,833
Medical doctors not included above	172.44	39,246	1,915	1,784	42,945	-	-	42,945	145.80	38,293
Regulated nurses not included above										
RNs, Reg. Psych. Nurses, Grad Nurses	16,764.59	1,393,227	147,697	260,926	1,801,850	448.00	23,644	1,825,494	16,798.32	1,703,557
LPNs	3,307.90	185,382	17,459	33,571	236,412	4.00	214	236,626	3,173.29	212,174
Other health technical and professional	12,580.79	920,933	62,565	182,842	1,166,340	69.00	2,433	1,168,773	11,514.77	1,009,512
Unregulated health service providers	6,047.78	256,139	17,952	46,315	320,406	18.00	866	321,272	5,923.17	288,813
Other staff	22,132.96	1,094,576	56,952	220,702	1,372,230	143.00	9,527	1,381,757	21,945.59	1,286,622
Costs to transfer employees to LAPP	-	-	-	33,000	33,000	-	-	33,000	-	7,000
	64,521.56	4,240,112	324,135	851,105	5,415,352	918.00	60,780	5,476,132	63,114.04	4,975,115
Total	64,547.80	$4,244,194	$325,913	$851,950	$5,422,057	920.00	$61,203	$5,483,260	63,219.41	$ 5,021,985

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2010

Supplemental Pension Plan (SPP)

	2010			2009			
	Current Service Cost	Other SERP Costs	Total	Total	Accrued Benefit Obligation March 31, 2009	Change in Accrued Benefit Obligation	Accrued Benefit Obligation March 31, 2010
President and Chief Executive Officer	$ -	$ -	$-	$ -	$ -	$ -	$ -
Interim VP Internal Audit and Enterprise Risk Management – Contracted Service	-	-	-	-	-	-	-
VP Internal Audit and Enterprise Risk Management(n)	26	17	43	37	197	8	205
VP Internal Audit and Enterprise Risk Management(o)	-	-	-	-	-	-	-
Ethics and Compliance Officer	-	-	-	-	-	-	-
Executive VP and Chief Financial Officer	-	-	-	-	-	-	-
Executive VP, Corporate Services	-	-	-	-	-	-	-
Acting Executive VP, Corporate Services	-	-	-	-	-	-	-
Executive VP, Quality and Service Improvement	95	84	179	199	915	225	1,140
Executive VP, Rural, Public and Community Health	28	34	62	310	394	244	638
Executive VP, Strategy and Performance	-	-	-	-	-	-	-
Acting Executive VP, Strategy and Performance	30	16	46	26	141	(32)	109
Senior VP, Clinical Support Services	24	3	27	31	49	31	80
Senior Physician Executive	79	30	109	97	334	57	391
VP Community Engagement and Chief of Staff, Board Office	-	-	-	-	-	-	-
Chief of Staff, Board Office	17	8	25	29	87	(87)	-
Interim Chief Operating Officer, Health Strategies, Research and Design	37	9	46	53	210	15	225

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2010

a. Full time equivalents (FTE's) for Board Members are prorated using the number of days in the fiscal year between either the date of appointment or termination date (if applicable) and the end of the year. FTE's for staff are determined at the rate of 2,022.75 annual hours for each full-time employee. Total actual discrete number of individuals employed during the fiscal year was 94,715.

b. Base salary includes pensionable base pay as well as statutory and vacation accruals relating to the current fiscal year.

c. Other cash benefits include honoraria, bonuses, overtime, vacation payouts and lump sum payments.

d. Other non-cash benefits include:

- Employer's current and prior service cost of supplemental pension plans (f).
- Share of all employee benefits and contributions or payments made on behalf of employees including pension, health care, dental coverage, vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, long and short term disability plans.
- Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

e. Severance includes direct or indirect payments to individuals upon termination or voluntary exit, which are not included in other cash benefits.

f. Supplemental Pension Plans (SPP)

Under the SPP certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service post 1991 based on the employee's service and earnings. The SPP costs are not cash payments in the period but are the cost for the period for rights to these future retirement benefits. Current service cost is the actuarial present value of the benefits earned in the fiscal year. Other SPP costs include interest cost on the obligations and current service cost, the amortization of past service cost, initial obligations and net actuarial gains and losses, offset by the expected return on the plans' assets. Changes in the accrued benefit obligation include current service cost, interest accruing on the obligations and the current service cost as well as the full amount of any actuarial gains or losses in the period. The SPP is disclosed in Notes 2(i) and 14(c).

g. Incumbent's other non-cash benefits include an amount for the maximum contribution to a registered retirement savings plan. Upon the completion of each five full years of employment the incumbent will be entitled to one year of paid sabbatical leave. An amount will be recorded in the accounts of AHS at the end of each full five years of employment.

h. Incumbents are provided with an automobile allowance. Dollar amounts are included in other cash benefits (c).

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2010

i. Incumbents are provided with an automobile. Dollar amounts are not included in other non-cash benefits (d).

j. Incumbent's other cash benefits include a lump-sum retroactive premium payment relating to the prior year.

k. Incumbent's other cash benefits include a lump-sum retroactive salary payment relating to the prior year.

l. Incumbent is on secondment from the University of Calgary. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary. AHS reimburses the University for the incumbent's rank salary, honorarium and market supplements; all amounts have been included in base salary.

m. Incumbent is on secondment from the University of Calgary. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary. AHS reimburses the University for the incumbent's rank salary; all amounts have been included in base salary.

Appointments and Departures

n. Position held by incumbent until October 9, 2009.

o. Position held by incumbent from October 5, 2009 until March 5, 2010.

p. Incumbent held the position of Special Assistant to the Chief Operating Officer, Corporate Services until May 12, 2009 at which time the incumbent was appointed to Acting Executive VP, Corporate Services until July 31, 2009.

q. From July 6 – 31, 2009 this position was held by two incumbents as the acting incumbent (p) remained on acting in a transitional capacity until that date.

r. Incumbent held the position of Chief Operating Officer, Urban until May 12, 2009 at which time the position was eliminated and the incumbent was appointed to Executive VP, Quality and Service Improvement.

s. Incumbent appointed to position effective April 14, 2009.

t. Incumbent appointed to position effective November 4, 2009.

u. Incumbent held the position of Interim Chief Operating Officer, Change Management until May 12, 2009 at which time the position was eliminated and the incumbent was appointed to the position of Acting Executive VP, Strategy and Performance until November 4, 2009. The incumbent held two other positions throughout the year: Acting Executive VP and Chief Financial Officer (April 1 – 14, 2009) and Special Assistant to the Chief Executive Officer, Corporate Services (May 12, 2009 – January 2, 2010). The Special Assistant position has been vacant since the incumbent's departure.

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2010

v. Incumbent held the position of Chief Operating Officer, Performance Improvement and Clinical Support Services until May 12, 2009 at which time the position was eliminated and the incumbent was appointed to Senior VP, Clinical Support Services.

w. Incumbent held the position of Chief Operating Officer, Community and Rural until May 12, 2009 at which time the position was eliminated and the incumbent was appointed to Executive VP, Rural, Public and Community Health.

x. Incumbent appointed to position effective November 2, 2009.

y. Position held by incumbent until November 2, 2009.

z. Position held by incumbent until April 30, 2009 at which time the position was eliminated.

Termination Liabilities

aa. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 12 months base salary at the rate in effect at the date of termination. The incumbent will also be paid 15% of the severance in lieu of all other benefits as well as relocation expenses not to exceed $20,000.

bb. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 12 months base salary at the rate in effect at the date of termination. The incumbent will also be paid 15% of the severance in lieu of all other benefits.

cc. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive a maximum severance pay of 17 months base salary (1) and premium payments at the rate in effect at the date of termination. The incumbent will also receive the incentive bonus for the prior two years divided by 24 months multiplied by a maximum of 17 months and up to 17 months of the total cost of the incumbent's benefits. AHS will also make payment for the incumbent to attend an outplacement program for 6 months.

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2010

dd. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 24 months base salary at the rate in effect at the date of termination. The incumbent will also be paid an amount equal to 24 months of AHS's cost of benefits.

ee. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will be provided with a severance package equivalent to 12 months salary and benefits plus one additional month per year of service provided to a maximum of 24 months.

ff. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to a maximum of 18 months base salary (m) and premium payments at the rate in effect at the date of termination. The incumbent will also be paid an amount up to 18 months of the total cost of the incumbent's benefits. AHS will also make payment for the incumbent to attend an outplacement program for 6 months.

gg. The incumbent's termination benefits have not been predetermined.

hh. Based on the provisions of the applicable SPP (f), the following outlines the benefits received by individuals who departed within the 2009-2010 fiscal period:

Position	Benefit (not in thousands)	Frequency	Payment Terms
VP Internal Audit and Enterprise Risk Management (n)	$ 1,170	Monthly	Indefinite
Acting Executive VP, Strategy and Performance	110,067	Lump-Sum	One-Time
Chief of Staff, Board Office	92,720	Lump-Sum	One-Time
Interim Chief Operating Officer, Health Strategies, Research and Design	1,341	Monthly	Indefinite

CONSOLIDATED SCHEDULE OF BUDGET FOR THE YEAR ENDED MARCH 31, 2010

	Original Financial Plan	Additional Reclassifications	Reported Budget
Revenue			
Alberta Health and Wellness contributions	$ 8,399,000	$ 31,022	$ 8,430,022
Other government contributions	70,000	10,980	80,980
Fees and charges	575,000	9,991	584,991
Ancillary operations	113,000	(4,419)	108,581
Donations	19,000	(3,332)	15,668
Investment and other income	286,000	(39,016)	246,984
Amortization of external capital contributions	300,000	635	300,635
TOTAL REVENUE	9,762,000	5,861	9,767,861
Expenses			
Inpatient acute nursing services	2,575,000	158,440	2,733,440
Emergency and outpatient services	1,199,000	(52,619)	1,146,381
Facility-based continuing care services	872,000	(84,138)	787,862
Ambulance services	329,000	(13,082)	315,918
Community-based care	603,000	127,069	730,069
Home care	388,000	(20,193)	367,807
Diagnostic and therapeutic services	1,806,000	(82,992)	1,723,008
Promotion, prevention and protection services	345,000	(4,611)	340,389
Research and education	256,000	(52,341)	203,659
Administration	340,000	99,696	439,696
Information technology	289,000	(37,840)	251,160
Support services	1,491,000	(59,012)	1,431,988
Amortization of facilities and improvements	154,000	13,584	167,584
Funded transition costs	-	13,900	13,900
TOTAL EXPENSES	10,647,000	5,861	10,652,861
Deficiency of revenue over expenses	$ (885,000)	$ -	$ (885,000)

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF BUDGET
MARCH 31, 2010
(thousands of dollars)

	Original Financial Plan	Additional Reclassifications	Reported Budget
Expenses by object			
Salaries and benefits	$ 5,482,000	$ 11,130	$ 5,493,130
Contracts with health service providers	1,808,000	(91,432)	1,716,568
Contracts under the Heath Care Protective Act	23,000	855	23,855
Drugs and gases	386,000	(51,405)	334,595
Medical and surgical supplies	410,000	(73,509)	336,491
Other contracted services	1,014,000	134,410	1,148,410
Other	1,058,000	137,176	1,195,176
Amortization			
Equipment – internally funded	86,000	(4,735)	81,265
Equipment – externally funded	227,000	(77,595)	149,405
Facilities and improvements – internally funded	79,000	(64,646)	14,354
Facilities and improvements – externally funded	73,000	71,531	144,531
Loss on disposal of capital assets	1,000	14,081	15,081
TOTAL EXPENSES BY OBJECT	$ 10,647,000	$ 5,861	$ 10,652,861

CONSOLIDATED SCHEDULE OF COMPARATIVES
FOR THE YEAR ENDED MARCH 31, 2010

	As Previously Reported by Former Health Entities	Eliminations	Reclassifications and Adjustments	As Restated
Revenue				
Alberta Health and Wellness contributions	$ 8,224,844	$ (12,307)	$ 15,125	$ 8,227,662
Other government contributions	173,545	(82,305)	(24,594)	66,646
Fees and charges	544,417	(201)	(1,600)	542,616
Ancillary operations	115,329	-	2,323	117,652
Donations	24,959	-	414	25,373
Research and education	58,690	-	(58,690)	-
Investment and other income	281,437	(74,453)	75,698	282,682
Amortized external capital contributions	323,009	-	(79)	322,930
TOTAL REVENUE	$ 9,746,230	$ (169,266)	$ 8,597	$ 9,585,561
Expenses				
Inpatient acute nursing services	$ 2,421,861	$ (19,938)	$ (3,172)	$ 2,398,751
Emergency and outpatient services	1,142,718	(17,510)	(26,002)	1,099,206
Facility-based continuing care services	759,204	(282)	(2,692)	756,230
Ambulance services	19,805	-	24,165	43,970
Community-based care	541,496	(34,705)	39,189	545,980
Home care	401,143	(965)	(7,019)	393,159
Diagnostic and therapeutic services	1,741,377	(25,643)	1,746	1,717,480
Promotion, prevention and protection services	298,979	(1,551)	(434)	296,994
Research and education	229,866	(816)	(1,684)	227,366
Administration	346,997	(31,967)	9,326	324,356
Information technology	290,885	(1,740)	(8,195)	280,950
Support services	1,479,952	(8,514)	(29,780)	1,441,658
Amortization of facilities and improvements	162,052	-	(661)	161,391
Capital assets write down	-	-	13,810	13,810
Funded transition costs	66,196	(25,635)	-	40,561
TOTAL EXPENSES	$ 9,902,531	$ (169,266)	$ 8,597	$ 9,741,862

SCHEDULE 4 - CONSOLIDATED SCHEDULE OF COMPARATIVES
MARCH 31, 2010
(thousands of dollars)

	As Previously Reported by Former Health Entities	Eliminations	Reclassifications and Adjustments	As Restated
Assets				
Cash	$ 1,048,310	$ -	$ 95,913	$ 1,144,223
Accounts receivable	214,797	(54,097)	(1,479)	159,221
Contributions receivable from Alberta Health and Wellness	35,671	-	512	36,183
Inventories	91,108	-	1	91,109
Prepaid expenses	46,508	(515)	51	46,044
Investments (non-current cash)	1,903,219	-	(95,900)	1,807,319
Capital assets	5,539,415	-	(8)	5,539,407
Capital contributions receivable from Alberta Health and Wellness	23,641	-	(7,141)	16,500
Contributions receivable	44,699	-	(44,699)	-
Non-current advances – continuing care partnerships	8,381	-	(8,381)	-
Loans - continuing care partnership projects	68,155	-	(68,155)	-
Other assets	33,378	(14,381)	125,789	144,786
TOTAL ASSETS	$ 9,057,282	$ (68,993)	$ (3,497)	$ 8,984,792
Liabilities				
Accounts payable and accrued liabilities	$ 969,667	$ (68,993)	$ 2,049	$ 902,723
Accrued vacation pay	339,511	-	(8,912)	330,599
Deferred contributions current	551,340	-	79,280	630,620
Current portion of long-term debt	12,717	-	(649)	12,068
Deferred contributions non-current	121,080	-	60,266	181,346
Deferred contributions – continuing care partnership projects	92,769	-	(92,769)	-
Deferred contributions – Healthy Aging Partnership	2,704	-	(2,704)	-
Deferred capital contributions	1,740,794	-	(44,018)	1,696,776
Long-term debt	190,978	-	(1,762)	189,216
Asset retirement obligation	9,928	-	(9,928)	-
Long-term employee benefit liabilities	9,429	-	(9,429)	-
Life lease deposit	13,625	-	(13,625)	-
Other liabilities	6,343	-	39,081	45,424
Unamortized external capital contributions	4,675,236	-	(6)	4,675,230
TOTAL LIABILITIES	$ 8,736,121	$ (68,993)	$ (3,126)	$ 8,664,002
Net assets (a)				
Accumulated surplus (deficit)	$ (342,818)	$ -	$ (401)	$ (343,219)
Accumulated net unrealized gains (losses) on investments	(17,738)	-	1	(17,737)
Internally restricted net assets invested in capital assets	671,265	-	331	671,596
Endowments	10,452	-	(302)	10,150
TOTAL NET ASSETS	$ 321,161	$ -	$ (371)	$ 320,790
TOTAL LIABILITIES AND NET ASSETS	$ 9,057,282	$ (68,993)	$ (3,497)	$ 8,984,792

SCHEDULE 4 - CONSOLIDATED SCHEDULE OF COMPARATIVES
MARCH 31, 2010
(thousands of dollars)

	As Previously Reported by Former Health Entities	Eliminations	Reclassifications and Adjustments	As Restated
Expense by object				
Salaries and benefits	$ 5,024,925	$ (826)	$ (2,114)	$ 5,021,985
Contracts with health service providers	1,710,784	(72,571)	2,238	1,640,451
Contracts under the Health Care Protection Act	21,255	-	870	22,125
Drugs and gases	323,374	(6,229)	18	317,163
Medical and surgical supplies	322,335	(1,043)	(119)	321,173
Other contracted services	956,909	(34,366)	(781)	921,762
Interest on long-term debt	7,091	-	(7,091)	-
Other expenses	1,058,945	(5,206)	15,813	1,069,552
Amortization				
Equipment - internally funded	80,836	-	(166)	80,670
Equipment - externally funded	153,509	-	-	153,509
Facilities and improvements - internally funded	18,995	-	-	18,995
Facilities and improvements - externally funded	148,826	-	-	148,826
Loss on disposal of assets	11,912	-	(71)	11,841
Capital assets write down	13,810	-	-	13,810
Funded transition costs	49,025	(49,025)	-	-
TOTAL EXPENSES	$ 9,902,531	$ (169,266)	$ 8,597	$ 9,741,862

(a) Net asset adjustments include:

- Transfer of expendable investment proceeds from endowments to deferred contributions.
- Transfer of previous repayments of long term debt used to fund capital assets from accumulated surplus (deficit) to internally restricted net assets invested in capital assets.

UNAUDITED CONSOLIDATED SCHEDULE OF FACILITIES AND SITES AS AT MARCH 31, 2010

The operations of the following facilities and sites are included in these financial statements:

Calgary and Area

Location	Facility		Facility Type** A/CC/P/ SL/O
Airdrie	Bethany Care Centre - Airdrie		CC
Banff	Mineral Springs Hospital		A,CC
Black Diamond	Oilfields General Hospital	*	A,CC
Calgary	Agape Hospice		CC
Calgary	Alberta Children's Hospital	*	A
Calgary	Approved Homes – Mental Health		O
Calgary	Aspen Family and Community Network (Eating Disorder Clinic)		O
Calgary	Aventa Addiction Treatment for Women		O
Calgary	Bethany Harvest Hills		CC
Calgary	Beverly Centre – Lake Midnapore		CC,SL
Calgary	Bow Crest Care Centre		CC
Calgary	Bow View Manor		CC
Calgary	Calgary Alpha House		O
Calgary	Canadian Mental Health Association		O
Calgary	Canadian Mental Health Association (Hamilton House)		O
Calgary	Carewest Dr. Vernon Fanning	*	CC
Calgary	Centre		
Calgary	Carewest George Boyack	*	CC
Calgary	Carewest Royal Park	*	CC
Calgary	Carewest Sarcee	*	CC
Calgary	Carewest Signal Pointe	*	CC
Calgary	Colonel Belcher Care Centre	*	CC,SL
Calgary	Eau Claire Retirement Residence		SL
Calgary	Edgemont Retirement Residence		SL
Calgary	Father Lacombe Care Centre		CC
Calgary	Foothills Medical Centre	*	A
Calgary	Forest Grove Care Centre		CC
Calgary	Fresh Start Recovery Centre		O
Calgary	Glamorgan Care Centre		CC
Calgary	Intercare Brentwood Care		CC
Calgary	Centre		CC
Calgary	Intercare Chinook Care Centre		CC
	Intercare Southwood Care Centre		

Location	Facility		Facility Type** A/CC/P/ SL/O
Calgary	Jackson Willan Seniors' Residence		SL
Calgary	Mayfair Care Centre		CC
Calgary	McKenzie Towne Care Centre		CC,SL
Calgary	Millrise Place		SL
Calgary	Mount Royal Care Centre		CC
Calgary	Oxford House		O
Calgary	Personal Care Homes - Continuing Care		SL
Calgary	Peter Lougheed Centre	*	A
Calgary	Recovery Acres		O
Calgary	Renfrew Recovery Centre	*	O
Calgary	Rockyview General Hospital	*	A
Calgary	Salvation Army		O
Calgary	Scenic Acres Retirement Residence		SL
Calgary	Southern Alberta Foresenic Psychiatric Centre	*	P
Calgary	Sunnyhill Wellness Centre		SL
Calgary	Sunrise Native Addiction Services Society		O
Calgary	Wing Kei Care Centre		CC
Calgary	Youth Detoxification and Residential Services	*	O
Calgary	Youville Women's Residence		O
Canmore	Canmore General Hospital	*	A,CC
Carmangay	Little Bow Continuing Care Centre	*	CC
Claresholm	Lander Treatment Centre		O
Claresholm	Claresholm Centre for Mental Health and Addictions	*	P
Claresholm	Claresholm General Hospital	*	A
Claresholm	Willow Creek Continuing Care Centre	*	CC
Didsbury	Didsbury District Health Services	*	A,CC
High River	High River General Hospital	*	A,CC
Okotoks	Foothils Country Hospice		CC
Strathmore	Strathmore District Health Services	*	A,CC
Vulcan	Extendicare Vulcan		CC
Vulcan	Vulcan Community Health Centre	*	A,CC

*Operated by AHS

** A = Acute care facility, CC = Continuing care facility, P = Psychiatric facility, SL = Supportive Living, O = Other

SCHEDULE 5 – UNAUDITED CONSOLIDATED SCHEDULE OF FACILITIES AND SITES

MARCH 31, 2010

Camrose and Area

Location	Facility		Facility Type** A/CC/P/SL/O
Bashaw	Bashaw Care Centre	*	CC
Camrose	Bethany Meadows		CC,SL
Camrose	Faith House		SL
Camrose	Louise Jensen Care Centre		CC
Camrose	Memory Lane		CC
Camrose	Rosehaven Care Centre		CC
Camrose	St Mary's Hospital		A
Camrose	Viewpoint		CC
Daysland	Daysland - Providence Place		SL
Daysland	Daysland Health Centre	*	A
Galahad	Galahad Care Centre	*	CC
Hardisty	Hardisty Health Centre	*	A,CC
Islay	Islay Assisted Living	*	SL
Killam	Killam Health Care Centre		A,CC
Lamont	Lamont Health Care Centre		A,CC
Lloydminster	Lloydminster - Points West Living		SL

Location	Facility		Facility Type** A/CC/P/SL/O
Lloydminster	Slim Thorpe Recovery Centre		O
Mannville	Mannville Care Centre	*	CC
Mundare	Mary Immaculate Hospital		CC
Myrnam	Myrnam - Eagleview Lodge		SL
Provost	Provost Health Centre	*	A,CC,SL
Tofield	Tofield Health Centre	*	A,CC
Two Hills	Two Hills Health Centre	*	A,CC
Vegreville	Century Park	*	SL
Vegreville	Heritage House		SL
Vegreville	Vegreville Care Centre	*	CC
Vermilion	Vermilion Health Centre	*	A,CC
Vermilion	Vermilion Valley Lodge Supportive Housing		SL
Viking	Viking Extendicare		CC
Viking	Viking Health Centre	*	A
Wainwright	Wainwright Health Centre	*	A,CC

Edmonton and Area

Location	Facility		Facility Type** A/CC/P/SL/O
Alexander Reserve	Kipohtakawmik Elders Lodge		SL
Devon	Devon General Hospital	*	A,CC
Edmonton	Henwood Treatment Centre	*	O
Edmonton	Recovery Centre	*	O
Edmonton	Youth Detoxification and Residential Services	*	O
Edmonton	Alberta Hospital Edmonton	*	P
Edmonton	All Seniors Care Rutherford		SL
Edmonton	Allen Gray Continuing Care Centre		CC
Edmonton	Capital Care - Laurier House	*	SL
Edmonton	Capital Care - McConnell Place North	*	SL
Edmonton	Capital Care - McConnell Place West	*	SL
Edmonton	Capital Care Dickensfield	*	CC
Edmonton	Capital Care Dickensfield	*	SL
Edmonton	Duplexes YAP		
Edmonton	Capital Care Grandview	*	CC
Edmonton	Capital Care Lynnwood	*	CC
Edmonton	Capital Care Norwood	*	CC
Edmonton	Christenson Developments Devonshire Manor		SL

Location	Facility		Facility Type** A/CC/P/SL/O
Edmonton	Cross Cancer Institute	*	A
Edmonton	Devonshire Care Centre		CC
Edmonton	Edmonton Chinatown Care Centre		CC,SL
Edmonton	Edmonton General Continuing Care Centre		CC
Edmonton	Edmonton People In Need #4 - Batoma House		SL
Edmonton	Emmanuel Home		SL
Edmonton	Excel Society - Grand Manor		SL
Edmonton	Extendicare Holyrood		CC
Edmonton	Extendicare Somerset		CC
Edmonton	George Spady Centre Society		O
Edmonton	Glenrose Rehabilitation Hospital	*	A
Edmonton	Good Samaritan Dr. Gerald Zetter Care Centre		CC
Edmonton	Good Samaritan Wedman House		SL
Edmonton	Grey Nuns Community Hospital		A
Edmonton	Innovative Housing - Gravelle		SL
Edmonton	Innovative Housing – Villa Marguerite		SL
Edmonton	Jellinek House		O
Edmonton	Jubilee Lodge Nursing Home		CC

*Operated by AHS

** A = Acute care facility, CC = Continuing care facility, P = Psychiatric facility, SL = Supportive Living, O = Other

Edmonton and Area (continued)

Location	Facility		Facility Type** A/CC/P/ SL/O
Edmonton	Kensington Village Continuing Care Centre		CC,SL
Edmonton	Lifestyle Options - Leduc		SL
Edmonton	Lifestyle Options - Riverbend		SL
Edmonton	Lifestyle Options - Terra Losa		SL
Edmonton	McDougall House		O
Edmonton	Misericordia Community Hospital		A
Edmonton	Our House		O
Edmonton	Oxford House		O
Edmonton	Recovery Acres Edmonton		O
Edmonton	Revera Retirement LP - Churchill		SL
Edmonton	Revera Retirement LP - Riverbend		SL
Edmonton	Rosedale Estates		SL
Edmonton	Rosedale Griesbach		SL
Edmonton	Royal Alexandra Hospital	*	A
Edmonton	Salvation Army Grace Manor		SL
Edmonton	Salvation Army Supportive Residence		SL
Edmonton	Shepherd's Care Foundation - Garden		SL
Edmonton	Shepherd's Care Foundation - Golden Age Manor		SL
Edmonton	St. Joseph's Auxiliary Hospital		CC
Edmonton	St. Michael's Long Term Care Centre		CC
Edmonton	St. Thomas Health Centre		SL
Edmonton	Stollery Children's Hospital	*	A
Edmonton	The Dianne and Irving Kipnes Centre for Veterans	*	CC
Edmonton	The Waterford of Summerlea (Retirement Home)		SL
Edmonton	Touchmark at Wedgewood		CC
Edmonton	University of Alberta Hospitals	*	A
Edmonton	Venta Care Centre		CC
Edmonton	Wildrose Cottage (Chartwell Seniors Housing)		SL
Fort Saskatchewan	Fort Saskatchewan Health Centre	*	A
Fort Saskatchewan	Rivercrest Care Centre		CC
Leduc	Extendicare Leduc		CC
Leduc	Leduc Community Hospital	*	A,CC
Leduc	Salem Manor Nursing Home		CC
Morinville	Aspen House	*	SL
Redwater	Redwater Health Centre	*	A,CC
Sherwood Park	All Seniors Care Summerwood		SL
Sherwood Park	Capital Care Strathcona	*	CC,SL
Sherwood Park	Country Cottage - Chartwell		SL
Sherwood Park	Sherwood Park Care Centre		CC
Spruce Grove	Good Samaritan Spruce Grove Centre		SL
St Albert	Poundmaker's Lodge Treatment Centre		O
St. Albert	Citadel Care Centre		CC
St. Albert	Sturgeon Community Hospital	*	A
St. Albert	Youville Auxiliary Hospital (Grey Nuns) of St. Albert		CC
Stony Plain	Good Samaritan George Hennig Place		SL
Stony Plain	The Good Samaritan Stony Plain		CC,SL
Stony Plain	WestView Health Centre - Stony Plain	*	A,CC
Various	Family Care Homes		O
Various	Mental Health Care Homes		O
Various	Personal Care Homes		SL
Villeneuve	West Country Hearth		SL

Fort McMurray and Area

Location	Facility		Facility Type** A/CC/P/ SL/O
Fort McMurray	Northern Lights Regional Health Centre	*	A,CC
Fort McMurray	Pastew Place Detox Centre		O
Fort Vermilion	St. Theresa General Hospital	*	A,CC
High Level	Action North Recovery Centre		O
High Level	Northwest Health Centre	*	A,CC
La Crete	La Crete Continuing Care Centre	*	CC

*Operated by AHS
** A = Acute care facility, CC = Continuing care facility, P = Psychiatric facility, SL = Supportive Living, O = Other

Grande Prairie and Area

Location	Facility		Facility Type** A/CC/P/ SL/O
Beaverlodge	Beaverlodge Municipal Hospital	*	A
Fairview	Fairview Health Complex	*	A,CC
Fox Creek	Fox Creek Healthcare Centre	*	A
Grande Cache	Grande Cache Community Health Complex	*	A,CC
Grande Prairie	Business & Industry Clinic	*	O
Grande Prairie	Northern Addiction Centre	*	O
Grande Prairie	Grande Prairie Care Centre		CC
Grande Prairie	Queen Elizabeth II Hospital	*	O
Grande Prairie	The Gardens at Emerald Park		SL
Grimshaw	Grimshaw/Berwyn & District Community Health Centre	*	CC
High Prairie	High Prairie Health Complex	*	A,CC
High Prairie	MITAA Centre		O
Hythe	Hythe Continuing Care Centre	*	CC
Manning	Manning Community Health Centre	*	A,CC
McLennan	Manoir du Lac		CC,SL
McLennan	Sacred Heart Community Health Centre	*	A
Peace River	Peace River Community Health Centre	*	A,CC
Spirit River	Central Peace Health Complex	*	A,CC
Valleyview	Valleyview Health Centre	*	A,CC

Jasper to Cold Lake

Location	Facility		Facility Type** A/CC/P/ SL/O
Athabasca	Athabasca Healthcare Centre	*	A,CC
Athabasca	Extendicare Athabasca		CC
Barrhead	Barrhead Healthcare Centre	*	A
Barrhead	Dr. W.R. Keir – Barrhead Continuing Care Centre	*	CC
Barrhead	Mental Health Spaces		O
Barrhead	Shepherd's Care Barrhead		SL
Bonnyville	Bonnyville Healthcare Centre		A,CC
Bonnyville	Bonnyville Indian Metis Rehabilitation Centre		O
Bonnyville	Extendicare Bonnyville		CC
Boyle	Boyle Healthcare Centre	*	A
Cold Lake	Cold Lake Healthcare Centre	*	A,CC
Desmarais	Wabasca/Desmarais Healthcare Centre	*	A
Edson	Edson Healthcare Centre	*	A,CC
Elk Point	Elk Point Healthcare Centre	*	A,CC
Hinton	Hinton Healthcare Centre	*	A
Hinton	Mountain View Centre		SL
Jasper	Evergreen Alpine - Jasper		SL
Jasper	Seton - Jasper Healthcare Centre	*	A
Lac La Biche	William J. Cadzow - Lac La Biche Healthcare Centre	*	A,CC
Mayerthorpe	Extendicare Mayerthorpe		CC
Mayerthorpe	Mayerthorpe Healthcare Centre	*	A,CC
Radway	Radway Continuing Care Centre	*	CC
Slave Lake	Slave Lake Healthcare Centre	*	A,CC
Smoky Lake	George McDougall – Smoky Lake Healthcare Centre	*	A,CC
Smoky Lake	Smoky Lake Continuing Care Centre	*	CC
St Paul	Extendicare St. Paul		CC
St Paul	Mental Health Spaces		O
St Paul	St. Therese - St. Paul Healthcare Centre	*	A,CC
Swan Hills	Swan Hills Healthcare Centre	*	A
Vilna	Vilna Villa		SL
Westlock	Smithfield Lodge		SL
Westlock	Westlock Healthcare Centre	*	A,CC
Whitecourt	Whitecourt Healthcare Centre	*	A

*Operated by AHS

** A = Acute care facility, CC = Continuing care facility, P = Psychiatric facility, SL = Supportive Living, O = Other

Lethbridge and Area

Location	Facility		Facility Type** A/CC/P/SL/O
Blairmore	Crowsnest Pass Health Centre	*	A,CC
Blairmore	York Creek Lodge		SL
Cardston	Cardston Health Centre	*	O
Cardston	Cardston Lodge		SL
Cardston	Grandview Nursing Home	*	CC
Coaldale	Coaldale Health Centre	*	O
Coaldale	Sunny South Lodge		SL
Fort MacLeod	Extendicare Fort MacLeod		O
Fort MacLeod	Foothills Detox Centre		O
Fort MacLeod	Fort MacLeod Health Centre	*	O
Fort MacLeod	Pioneer Lodge		SL
Lethbridge	Chinook Regional Hospital	*	A
Lethbridge	Columbia House Lethbridge		SL
Lethbridge	Edith Cavell Care Centre		CC
Lethbridge	Extendicare Lethbridge		CC
Lethbridge	Golden Acres		SL
Lethbridge	Good Samaritan Park Meadows Village		O
Lethbridge	Good Samaritan West Highlands		SL

Location	Facility		Facility Type** A/CC/P/SL/O
Lethbridge	South Country Treatment Centre		O
Lethbridge	Southern Alcare Manor		O
Lethbridge	St Michael's Health Centre		O
Lethbridge	St Michael's Health Centre - St. Therese Villa		SL
Magrath	Good Samaritan Garden Vista		O
Milk River	Milk River Health Centre	*	O
Milk River	Prairie Rose Lodge		SL
Picture Butte	PChAD Protective Safe House	*	O
Picture Butte	Piyami Lodge		SL
Picture Butte	Piyami Place		O
Pincher Creek	Good Samaritan Pincher Creek Vista Village		O
Pincher Creek	Pincher Creek Health Centre	*	A,CC
Raymond	Raymond Health Centre	*	O
Taber	Clearview Lodge		SL
Taber	Taber Health Centre	*	A,CC

Medicine Hat and Area

Location	Facility		Facility Type** A/CC/P/SL/O
Bassano	Bassano Health Centre	*	A,CC
Bow Island	Bow Island Health Centre	*	A,CC
Brooks	Brooks Health Centre	*	A,CC
Brooks	Orchard Manor		SL
Medicine Hat	Chinook Village		SL
Medicine Hat	Club Sierra		CC
Medicine Hat	Leisure Way		SL

Location	Facility		Facility Type** A/CC/P/SL/O
Medicine Hat	Meadow Lands		SL
Medicine Hat	Medicine Hat Regional Hospital	*	A
Medicine Hat	Riverview Care Centre		CC
Medicine Hat	South Ridge Village		CC,SL
Medicine Hat	The Valleyview		CC,SL
Oyen	Big Country Hospital	*	A,CC

*Operated by AHS

** A = Acute care facility, CC = Continuing care facility, P = Psychiatric facility, SL = Supportive Living, O = Other

Red Deer and Area

Location	Facility		Facility Type** A/CC/P/ SL/O
Bentley	Bentley Care Centre	*	CC
Breton	Breton Health Centre	*	CC
Castor	Our Lady of the Rosary Hospital		A,CC
Consort	Consort Hospital and Care Centre	*	A,CC
Coronation	Coronation Hospital and Care Centre	*	A,CC,SL
Drayton Valley	Drayton Valley Hospital and Care Centre	*	A,CC
Drayton Valley	Serenity House	*	SL
Drumheller	Drumheller Health Centre	*	A,CC
Drumheller	Grace House		O
Eckville	Eckville Manor House		SL
Hanna	Hanna Health Centre	*	A,CC
Innisfail	Innisfail Health Centre	*	A,CC
Lacombe	Lacombe Hospital and Care Centre	*	A,CC
Lacombe	Manor at Royal Oak Village (Good Samaritan Society)		SL
Linden	Linden Nursing Home		CC
Olds	Olds Hospital and Care Centre	*	A,CC
Olds	Sunrise Village Olds (Continuum HealthCare Corp)		SL
Ponoka	Centennial Centre for Mental Health and Brain Injury	*	P
Ponoka	Northcott Care Centre (Ponoka)		CC
Ponoka	Ponoka Hospital and Care Centre	*	A,CC
Ponoka	Sunrise Village Ponoka (Continuum HealthCare Corp)		SL

Location	Facility		Facility Type** A/CC/P/ SL/O
Red Deer	Bethany CollegeSide (Red Deer)		CC
Red Deer	Kentwood Place	*	O
Red Deer	Pines Lodge - Piper Creek Foundation		SL
Red Deer	Red Deer Nursing Home	*	CC
Red Deer	Red Deer Regional Hospital Centre	*	A
Red Deer	Safe Harbour Society		O
Red Deer	Valley Park Manor (Red Deer)	*	CC
Rimbey	Rimbey Hospital and Care Centre	*	A,CC
Rocky Mountain House	Clearwater Centre (Rocky Mountain House)		CC,SL
Rocky Mountain House	Rocky Mountain House Health Centre	*	A
Stettler	Stettler Hospital and Care Centre	*	A,CC
Sundre	Sundre Hospital and Care Centre	*	A,CC
Sylvan Lake	Bethany Sylvan Lake		CC,SL
Three Hills	Three Hills Health Centre	*	A,CC
Trochu	St. Mary's Health Care Centre		CC
Wetaskiwin	Good Shepherd Lutheran Home		SL
Wetaskiwin	Peace Hills Lodge		SL
Wetaskiwin	Sunrise Village Wetaskiwin (Continuum HealthCare Corp)		SL
Wetaskiwin	Wetaskiwin Hospital and Care Centre	*	A,CC

In addition to the facilities listed above, these financial statements also include the operations of community health centres, public health clinics, research facilities, laboratory sites, community rehabilitation physiotherapy clinics, and hemodialysis satellites all operating within the Province.

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*Operated by AHS

** A = Acute care facility, CC = Continuing care facility, P = Psychiatric facility, SL = Supportive Living, O = Other

Appendix

SUPPLEMENTARY MEASURES

In addition to the required performance measures, AHS is expected to supplement its planning, management and monitoring of health system performance with other health system performance measures and indicators. These will support good governance, operational management of service delivery, and aid in monitoring and reporting on progress and results achieved for major health initiatives undertaken in collaboration with the Ministry and other stakeholders.

The Supplementary measures list is not exhaustive. Many of these measures were developed and implemented by AHW and former health authorities in previous years. Other health system performance measures may be developed, substituted and implemented as performance measures, information needs and reporting expectations evolve.

Key difference between performance measures identified in Required Measures and Supplementary Measures is that the former have specific targets attached to them with a view to demonstrate accountability. Performance Measures in Supplementary list do not have any targets attached to them and the goal here is performance improvement through ongoing monitoring. AHS is expected to monitor and report on their progress to the Minister on a quarterly basis for monitoring purposes as part of their Quarterly Reporting. These represent operational performance, continuous improvement opportunities, and health system priorities, and support AHS's and AHW's advisory roles to the Minister. The Minister will expect to receive this information, on short notice, when needed to support government's accountability to the public for the health system.

STRATEGIC GOAL #1: Providing the right service, in the right place, at the right time.

Priority: Access to cancer treatment

Timeliness of Care in Tertiary Oncology Facilities: Percentage meeting Target, Median Wait Time and 90th Percentile Wait Time

Wait times are an important measure of how quickly people are getting access to cancer care. They indicate Alberta Health Services' ability to meet the needs of cancer patients.

Wait times are commonly used as indicators of the efficiency of the system. A variety of factors can impact wait times such as the demographics of the population, treatment patterns of physicians, the number of emergency surgeries, which have higher priorities in use of resources, timing of first treatment, tumor site, and decisions to postpone treatment for medical or personal reasons.

Time Period 1: Referral to First Consult

For patients with a confirmed cancer diagnosis, the number of days to first consult between the date that a referral was received from a physician outside a cancer facility (eg, family physician or surgeon) to the date that the first consult with an oncologist occurred. In 2009/2010, the wait time was 7.1 weeks and the target was 4 weeks.

Time Period 2: Ready-to-Treat to First Radiation Therapy

The number of days from the date the patient is physically ready to commence treatment to the date the patient receives his/her first radiation therapy. In 2009/2010, the wait time was 5.6 weeks and the target was 4 weeks.

Radiation Therapy Corridor

In March 2007, through the Federal Government's Patient Wait Time Guarantee Trust, the Federal Minister of Health entered into a bi-lateral Agreement with Alberta to implement a "capacity corridor" as a key strategy for Alberta to increase the capacity for cancer radiation therapy services. The corridor strategy consists of building radiation treatment centers in Lethbridge, Red Deer, and Grande Prairie in association with other existing cancer treatment services.

The Lethbridge site is scheduled to become operational in June, 2010. Planning for the Red Deer site is underway and is scheduled to be operational in the fall of 2012. The Grande Prairie site is scheduled to be completed in 2013/14.

Application of Lean principles to radiation therapy services

Cancer Care radiation therapy stakeholders at the Tom Baker Cancer Centre and the Cross Cancer Institute worked with consultants from Alberta Finance and Enterprise to increase productivity in radiation therapy services in Alberta by applying Lean principles.

As a result of Lean improvements among other factors, the number of courses of radiation therapy provided in March 2010 was 11% higher than the average number of courses provided per month during 2008/2009 for the province.

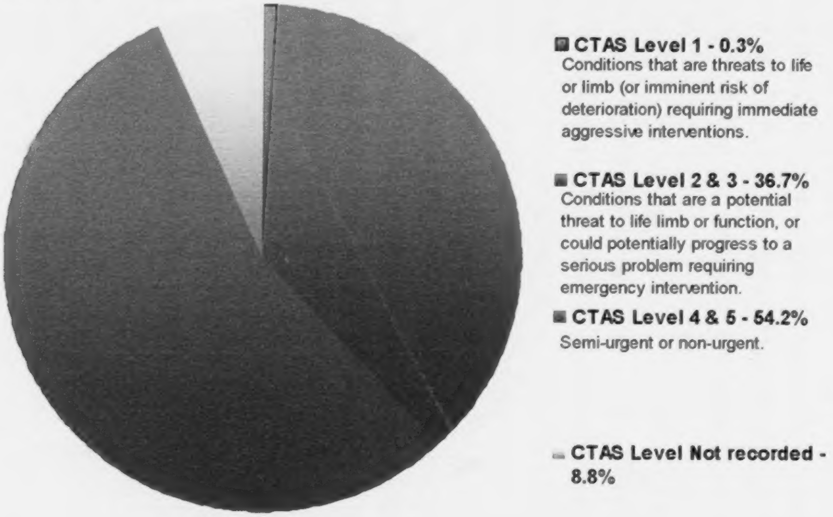
Priority: Access to diagnostic imaging services

Diagnostic Imaging	2008/2009	2009/2010					
CT Exams	**Alberta**	**South Zone**	**Calgary Zone**	**Central Zone**	**Edmonton Zone**	**North Zone**	**Total AHS**
Patient Waiting	n/a	626	4,287	1,656	3,330	1,527	**11,426**
Exams Completed	**419,000**	27,069	147,719	40,207	166,913	34,511	**416,419**
MRI Exams	**Alberta**	**South Zone**	**Calgary Zone**	**Central Zone**	**Edmonton Zone**	**North Zone**	**Total AHS**
Patient Waiting	n/a	2,376	17,860	1,728	7,032	1,922	**30,918**
Exams Completed	**147,000**	12,380	57,818	8,619	59,254	11,473	**149,544**

Priority: Increase the shift from hospital-based services to community based ambulatory care settings

- **Per cent of patient visits to emergency departments for less urgent or non-urgent care based on the Canadian Triage and Acuity Scale**

The Canadian Triage and Acuity Scale (CTAS) is a tool used to assess patients triaged at Emergency Departments. Percentage represents Albertans assessed to CTAS Level in 2008/2009.



- **Hospital readmission rates for targeted health conditions**

Readmission rates provide one measure of the quality of care. The risk of readmission following an in-patient stay may be related to the type of drugs prescribed at discharge, patient compliance with post-discharge therapy, the quality of follow-up care in the community, or the availability of appropriate diagnostic or therapeutic technologies during the initial hospital stay. Although readmission for medical conditions may involve factors outside the direct control of the hospital, high rates of readmission act as a signal to hospitals to look more carefully at their practices, including the risk of discharging patients too early and the relationship with community physicians and community-based care. All causes of readmissions are reported and are not necessarily due to related conditions. Unplanned readmissions are defined as those patients who had an urgent or emergent readmission excluding those admissions which were elective. Readmissions remain relatively steady across the zones.

Percentage of Patients with an Unplanned Hospital Readmission within 30 days of original visit by Zone 2008/2009

ZONE	% of Unplanned Readmissions within 30 days
South	8.33%
Calgary	6.31%
Central	9.50%
Edmonton	7.53%
North	9.56%*
Provincial Total	**7.61%**

Source: AHS Health Records
* 2008/09 Q4 results are not available for one site in the North Zone

- **Average length of stay for patients admitted to hospital**

Inpatient activity provides a context for hospital based reporting. Sites across the province serve different population sizes and have varying demands for services. The number of patients discharged by the facility in that quarter is a measure of activity. This can include patients with very short and very long stays.

The days of care delivered is measured by the total number of days the patients are in care. Patients admitted and discharged on the same day are counted as having received one day of care. All others in care for more than a day are calculated by the number of days from admission to discharge. These calculations assist in determining the average length of stay (LOS). The resulting average LOS becomes a measure of resource utilization for that facility.

There are many reasons why the average length of stay might vary. Complex procedures, sub acute and psychiatric conditions will typically be associated with longer hospital stays, as will stays associated with care later in life. Women admitted to hospital to give birth will typically have short stays so hospitals reporting a high number of births may also see a relatively lower average length of stay.

The length of stay needs to be understood in the context of the patient mix and procedures performed at that facility. Within this context, the average length of stay provides an indication of complexity of patients served within a particular hospital. Complexity, as well as operational efficiency are two potential reasons why certain facilities may exhibit a lower average length of stay as compared to other sites in the same peer group.

Average LOS* by Zone 2008/2009

ZONE	Average LOS in days*
South	5.9
Calgary	6.5
Central	6.2
Edmonton	6.8
North	4.7
Provincial Total	**6.3**

Source: AHS Health Records

* Length of stay excludes alternate level of care days.

Priority: Primary Health Care

Established key strategic partnerships to advance work across portfolios, with Zones and with Primary Care Networks (PCN's).

Development of Provincial Primary Care / Chronic Disease Management Leadership Committee.

Plan developed for Primary Health Care Strategy & Primary Care model under the overarching Transformational Improvement Program (TIP): "Building a Primary Care Foundation". The plan includes the development of strategies for funding, inter-professional teams, integration, and infrastructure to support the preferred Primary Care model.

"Discussion Paper on Primary Care Models" finalized and initial targeted consultation completed. Broad stakeholder consultation underway, including Alberta Clinicians Council, Alberta Medical Association (AMA), Health Advisory Councils, and Primary Care Networks.

Priority: Continuing Care

AHS continues to work to shift continuing care clients from facility living to community living as demonstrated in the:

- **Percent of Continuing Care Beds by the population aged 75 and over**

Long Term Care (LTC) and Supportive Living (SL) Based on Bed Survey as of March 31, 2010

Zone	LTC	SL3	SL4	Total	75+ Pop	Total Population	LTC / 1,000 75+	SL3 / 1,000 75+	SL4 / 1,000 75+	Total / 1,000 75+
South	1,074	260	649	1,983	18,562	282,060	58	14	35	107
Calgary	4,712	222	532	5,466	60,153	1,358,944	78	4	9	91
Central	2,345	565	69	2,979	27,288	444,672	86	21	3	109
Edmonton	4,932	414	2,214	7,560	60,244	1,146,858	82	7	37	125
North	1,328	37	204	1,569	15,840	431,844	84	2	13	99
TOTAL	14,391	1,498	3,668	19,557	182,087	3,664,378	79	8	20	107

Source: AHS Bed Survey

- **Number and percentage change Supportive Living (SL) spaces**

Zone	Supportive Living Level 3				Supportive Living Level 4				Total Supportive Living Levels 3 and 4			
	March 31, 2009	March 31, 2010	# Change	% Change	March 31, 2009	March 31, 2010	# Change	% Change	March 31, 2009	March 31, 2010	# Change	% Change
South	245	260	15	6%	474	649	175	27%	719	909	190	21%
Calgary	212	222	10	5%	495	532	37	7%	707	754	47	6%
Central	549	565	16	3%	59	69	10	14%	608	634	26	4%
Edmonton	402	414	12	3%	1,962	2,214	252	11%	2,364	2,628	264	10%
North	34	37	3	8%	204	204	0	0%	238	241	3	1%
AHS TOTAL:	1,442	1,498	56	4%	3,194	3,668	474	13%	4,636	5,166	530	10%

Source: AHS Bed Survey

- **Number of home care clients**

Number of Clients served by Community Care (Home Care and Supportive Living)*
Q3 (October 1, 2009 – December 31, 2009)

Zone	End-of-Life (0 – 6 months)	Short Term (< 90 days)	Long Term (> 90 days)	Unclassified	Totals
South	157	1,484	4,750	0	**6,391**
Calgary	17	925	17,629	0	**18,571**
Central	190	3,248	6,560	449	**10,447**
Edmonton	658	4,398	11,978	389	**17,423**
North	151	1,639	4,963	359	**7,112**

Source: AHS Coordinated Access
* Work is underway to develop definitions provincially. 2010/2011 data will be reported according to CIHI, ACCIS definitions (End-of-Life, Acute Care, Rehabilitation, Long-term Supportive, Maintenance and Wellness).

- **Number of self-managed care clients**

Number of Clients on Self Managed Care by Zone as of February 3, 2010	
Zone	Clients
South	62
Edmonton	416
Central	140
Calgary	508
North	96
Total Clients on Self Managed Care	**1,222**

Source: AHS Continuing Care

The following demonstrates the average wait time in days for Continuing Care Placement

Average Wait Time* – Waiting in Acute Care	Average Wait Time*(in days) for People Placed from September 1, 2009 – March 31, 2010 (7 months of data)
Waiting in Acute/Sub-acute for:	
Long Term Care Facility Living	30 days
Supportive Living Level 3	73 days
Supportive Living Level 4	64 days
Average Wait Time* in Acute/Sub-Acute for Continuing Care	**37 days**

Average Wait Time* – Waiting in the Community (at home)	Average Wait Time* (in days) for People Placed from September 1, 2009 – March 31, 2010 (7 months of data)
Waiting in Community at home for:	
Long Term Care Facility Living	101 days
Supportive Living Level 3	37 days
Supportive Living Level 4	81 days
Average Wait Time* in Community (at home) for Continuing Care	**86 days**

* Work is underway to develop definitions provincially regarding wait time methodology
Source: AHS Coordinated Access

Priority: Patient safety

Developed and implemented the initial steps of an AHS Patient Safety Approach including:

- Development of an AHS Quality Assurance Committee structure
- Development and launch of phase 1 of an AHS Reporting and Learning system for patient safety
- Development and initial implementation of a recommendation management system for AHS
- Continued real time support to clinical operations related to patient safety and adverse event management
- As of February 2010, the AHS Safe Surgery Checklist and User Manual has been implemented in 44 sites. The remaining 12 sites in AHS have scheduled implementation dates for May-June 2010.
- The new AHS Reporting & Learning System (RLS) was launched at the QEII hospital in Grande Prairie on March 31, 2010. The process will be evaluated for three months.
- The tracking of new internal recommendations will begin with those recommendations that arise from the new AHS Quality Assurance Committee structure following approval of the new structure on April 29, 2010.
- The Executive Patient Safety Recommendation Review Committee has been established. The purpose of this committee is to review selected recommendations that arise from both internal and external patient safety quality assurance reviews that have been identified as potentially requiring broad implementation and/or significant resources to implement.
- The proposed Quality and Patient Safety Dashboard was approved by the Board and released to the public in January.
- Standard protocol for collecting and reporting healthcare acquired cases of clostridium difficile associated diarrhea (CDAD) will be implemented January 1, 2011. Previously existing protocols will continue with reporting at the site and zone level until the province wide protocol is established. Patients with known or suspected CDAD are placed on contact isolation precautions. Emphasis is placed on hand hygiene and housekeeping procedures to control environmental contamination with clostridium difficile.
- Outbreak management algorithms have been developed for respiratory and gastrointestinal illness. These algorithms are in use as "working documents" as part of their final review.
- Infection Prevention and Control surveillance and reporting of procedure specific surgical site infections are conducted in all zones. Work continues to determine appropriate protocols to spread across zones and province wide.

Priority: Emergency Medical Services

Progress and results achieved toward transition of funding and governance of Emergency Medical Services from municipalities to Alberta Health Services (2009-10)

- Transition planned for completion on April 1, 2009 with contracts established with 64 services providers and assumed direct delivery of services from 12 services who elected to divest.

Length of time between receipt of level B, C, D, or E emergency calls and time of dispatch of emergency services

- Unable to measure with dispatch consolidation only partially complete.

Efficiencies related to improved utilization of EMS unit hours through coordination of EMS resources province-wide

- Unable to measure. No accurate baseline.

Progress and results achieved toward optimal use of paramedic's scope of practice, and expanded transport destination options, to better meet patient needs and improve service delivery

- Focus of first year was to establish and align EMS processes with AHS. Have seconded an advanced practitioner to Alberta College of Paramedics to work on practitioner competencies. Will begin to explore expansions to practice in Fall/Winter 2010/11.
- Expanded Urgent Care Drop Off at Sheldon Chumir and Airdrie Urgent Care Centre (UCC). Planning to utilize Okotoks UCC (designation as UCC recently received) UCC is underway.

STRATEGIC GOAL 2: Enhancing access to high quality services in rural areas.

Priority: Enhancing access to high quality services in rural areas

Rural Health Strategy Developed. Rural and Community Planning Framework developed, including Capability Framework, Community Assessment and Service Response Tool, Rural Impact Assessment, and Key Indicator tool.

Development of Provincial Community and Rural Steering Committee

Health Link will assist for preventative care and treatment purposes so as to increase access to health services in local communities. Also, Mental Health protocols reviewed and updated to ensure identification of at risk callers. Discussions initiated with Mental Health and Addictions area to determine future strategy for promotion.

Telehealth

Telehealth enables the delivery of health-related services and information via telecommunications technologies. Telehealth is a tool that connects AHS employees across the Province, in real time, to facilitate health services, administrative meetings, and education.

Telehealth plays a significant role in providing a patient-focused, quality health service that is accessible and sustainable for all Albertans. Telehealth enables collaboration using one of the largest and best integrated telehealth networks in North America.

Though videoconference technology is the most widely used Telehealth service, other communication devices – including peripheral medical devices, web-based applications, and home telehealth units – are supported by Telehealth.

Telehealth technology bridges the geographical distances that span our organization. Wherever you are, telehealth technology can facilitate collaborative meetings & administrative events taking place. Videoconferencing technologies – located at every AHS site & facility – are the primary tools used by Telehealth to connect our administrative workforce.

STRATEGIC GOAL 3: Matching workforce supply to demand for services.

Priority: Health Workforce – Matching workforce supply and demand

Formula – Vacancy Rate -Head Count (including casuals)

Total number of vacant head count (including casuals)	Divide by	Total current head count (including casuals)	Plus	Total number of vacant head count (including casuals)	Equals	Vacancy Rate – Head Count (including casuals)
25	/	400	+	25	=	**.059**

Formula – Vacancy Rate -Head Count (not including casuals)

Total number of vacant head count (not including casuals)	Divide by	Total current head count (not including casuals)	Plus	Total number of vacant head count (not including casuals)	Equals	Vacancy Rate – Head Count (not including casuals)
10	/	300	+	10	=	**.032**

Formula – Vacancy Rate -FTE (not including casuals)

Total number of vacant FTE (not including casuals)	Divide by	Total current FTE (not including casuals)	Plus	Total number of vacant FTE (not including casuals)	Equals	Vacancy Rate – FTE (not including casuals)
7	/	200	+	7	=	**.034**

Source: AHS Human Resources

Progress and results achieved in implementation of the Alberta Health Workforce Action Plan (2007-2016)

Alberta Health Services is committed to building on the strategies and actions highlighted in the Health Workforce Action Plan. Utilizing our strengths as a provincial organization we are positioned to ensure that the strategies and actions are implemented to result in a flexible health workforce that can easily respond to change.

To date, while we have been largely focused on building the organizational structure to support these initiatives some work has been focused on a number of actions highlighted in the Health Workforce Action Plan. An example of this is the No Unsafe Lift Program which is underway.

STRATEGIC GOAL 4: Improving co-ordination and delivery of care.

Priority: Integrated, coordinated health services delivery

Alberta Clinician Council

- On January 25th, the Alberta Clinician Council (ACC) was officially launched at its inaugural meeting in Edmonton with approximately 60 clinicians and health care leaders in attendance. The ACC is a forum where multidisciplinary front-line clinicians from across the province collectively apply their knowledge, experience and expertise to provide advice and support to Senior Executive and the Chief Executive Officer on significant clinical strategic issues and organizational priorities related to quality, access and patient safety
- Work is underway to develop an 18 month Action Plan which will outline specific strategies and initiatives on how the ACC can contribute to improving quality and patient safety with Alberta Health Services.

Clinical Networks

- Clinical Networks are formally structured, provincial, multidisciplinary groups of clinicians and health care leaders responsible for reviewing evidence-based clinical care, seeking out leading practices and ensuring those practices are applied consistently across the province
- Seven of nine Clinical Networks (including Addiction & Mental Health, Bone & Joint, Cardiac, Critical Care, Emergency, Respiratory and Surgery) are underway and in the process of determining their priority areas of focus and are establishing membership for their Clinical Network core teams and working groups
- Addiction & Mental Health Clinical Network identified two priority areas:
    - Developing and implementing clinical care pathways (beginning with depression)
    - Adopting a concurrent capable approach for addiction and mental illness screening
- Bone & Joint Clinical Network identified four priority areas:
    - Hip and Knee Arthroplasty (early spread of the new model of care across AHS, address wait time issues)
    - Arthritis (focus on referral and triage between primary care and specialist physicians)
    - Trauma (early focus on fractured hips and orthopedic consult line)
    - Soft tissue injury (early focus on acute knee injuries)
- Cardiac Clinical Network identified three priority areas:
    - Heart Failure
    - Acute Coronary Syndromes
    - Cardiac Imaging
- Surgery Clinical Network identified the following priority areas:
    - Access (wait times and capacity management for specific surgical services across AHS)
    - Quality Improvement and Patient Safety (including Safe Surgery Checklist, surgical site infections)
    - Oversee the accreditation process for the Surgery related standards
- Work is underway to establish the critical linkages and develop an effective strategy for engaging and communicating with this provincial "web/network" of stakeholders for each Network. Clinical Networks will be extending beyond their core team and working group members in identifying, developing, implementing and evaluating clinical practice improvements and quality and safety enhancements – they will be engaging front-line clinicians, operational leadership, medical leadership and the strategic business units

Priority: Improve information flow, access to patient information and encourage patient safety regardless of the care setting by use of information technology and information management

Progress and results achieved in development and implementation of the consolidated and integrated, province-wide health information system

A key pillar of the AHS IT Strategy is the consolidation, including optimization, of existing strong IT solutions. This pillar supports AHS's mandate of province-wide health service delivery, and the transition to a more coherent cost effective IT environment (the AHS IT organization currently manages 2,500+ systems).

Consolidation will also enable another pillar of the IT Strategy: an interactive continuity of care record which will enable clinicians across the continuum to share information and collaborate on care, and will support a Personal Health Portal for the public.

A range of 2009-2010 initiatives advanced the achievement of this objective:

- Adjustments were made to the IT organization structure to further enable province-wide IT planning and service delivery.
- Progress was made on the 'foundations' for integrated health information. Highlights for the year were the completion of strategies and start of planning for Unified Person Identification (patient/client and provider), and EMPI consolidation (Enterprise Master Person Index).
- Assessment work commenced as input to the selection of an integrated acute/ambulatory clinical information solution (CIS) for the long term.
  - Focusing on existing strong AHS vendor platforms, the assessment covers clinical and technical requirements, cost, speed to implementation, and other factors.
  - In 2010/2011, a CIS business case will be completed, a broad base of clinicians engaged to advise on selection, the experience of other organizations garnered and the vendor selection process undertaken.
  - While CIS implementation will be a multi-year initiative, the selection decision will point the direction for systems to be consolidated and optimized.
- Ambulatory capabilities were also assessed to prepare a go-forward roadmap, minimizing the range of tools for use in the period to CIS implementation and facilitating the latter.
  - During the year, the Edmonton ambulatory solution continued to be rolled out with the scheduling system; by year end, 116 clinics were live. In Calgary, the MS Clinic went live as a proof of concept of the EMR solution, and 10 pilot clinics were implemented on a scheduling solution.
  - Also in Edmonton, clinician engagement was launched for the design and rollout of the ambulatory solution (scheduler and EMR) to the Edmonton Clinic South, which is scheduled to open in 2012.
- Progress continued to be made on a range of initiatives to optimize the integrated IT platform (MEDITECH) in use in all rural hospitals, rural community, and rural continuing care settings in the north south and central zones, including the regional hospitals. The objective is to transition to a common set of modules and functionality, enabling improved information exchange and reporting.
- Related to the above, the seven non-metropolitan former health entities transitioned to a single Immunization IT solution. This initiative supported the H1N1 pandemic response, and also enables system access for mobile public health nurses and creates a single electronic immunization record for each rural client.
- Also in support of the H1N1 pandemic response, province-wide Health Information Management and Information Technology services, including people, processes and technologies, were put in place.
- Jointly with Alberta Health and Wellness, a Chronic Disease/Outbreak Management solution was selected for province-wide implementation.
- An architectural review and consolidation of Chronic Disease registries was launched in 2009-2010.
- In Calgary, existing functionality for CPOE (computerized physician order entry) and eMAR (electronic medication administration record) was extended to the Alberta Children's Hospital and to urgent care centres (Sheldon Shumir and South Calgary).
- The Calgary CPOE order sets were leveraged for implementation in rural Emergency Departments, along with a solution upgrade to optimize the rural platform, as noted above.
- Also in Calgary, the existing bed management system was extended to the Foothills Medical Centre.
- With the goal of bringing all Critical Care units province-wide onto a common IT platform, the solution was selected, the strategy and governance put in place, and design/build initiated in 2009/2010.
- Diagnostic and therapeutic systems also continued to be consolidated. A highlight for 2009/2010 was the Calgary laboratory consolidation.
- In Edmonton, work commenced to bring Home Care onto an IT solution already in use in AHS.
- An assessment of the population screening tools of the former Alberta Cancer Board for their province-wide application was conducted during the year.
- The prototype for a seamless discharge initiative was completed.
- Work commenced on collaboration strategies with Clinical Networks who will play a key role in setting directions for CIS and consolidation efforts.
- A Business Case for an Enterprise Content Management solution was completed, under the sponsorship of Health Information Management.
- The management of certain IT contracts was transitioned from clinical areas to AHS IT, better enabling the consolidation and optimization initiative.

Priority: Improve information flow, access to patient information and encourage patient safety regardless of the care setting by use of information technology and information management

Progress and results achieved in implementation of a province-wide Data Quality Plan:

Alberta Health Services has developed a Data Quality Framework and Plan with data quality targets. Numerous audits and reviews are completed monthly prior to submitting Ambulatory Care and Inpatient coded and abstracted data to MACAR.

Information technology renewal: Percent of IT budget for capital expenses; percent of IT budget for operational expenses:

2009/2010 Year End: Capital 27% and Operating 73% (includes Operating Projects)

Number of ISO 20000 controls implemented:

In 2009/2010, AHS progressed on the strategy and planning of ITIL best practices province-wide and on an IT Service Catalogue. ITIL adoption is considered as a step toward achieving ISO controls. To assess compliance and measure progress toward best practices, AHS will be adopting Cobit 4.1 controls.

The merger of the 12 former health entities (FHEs) brought together IT Service Desks with 12 distinct software products to manage tickets and service requests. Only two of these products were considered ITIL compliant and were in different stages of implementation maturity. In 2009, all investment in these products was put on hold until future directions were determined. The sections below describe in more detail the progress that was made during the 2009/2010 year.

In terms of ISO 17799 controls, 129 were implemented by year end.

Progress and results achieved in implementation of IT/ IM standards and controls:

From an IT Service Management perspective, 2009/2010 focused on following up the recommendations of a Spring 2009 AHS ITIL Assessment and launching initiatives to progress toward IT best practices in a planned and consistent manner province-wide. The work of the former health entities on ITIL processes and technology enhancements was put on hold while planning for the provincial mandate was completed.

Initiatives launched during the year included:

- July 2009 - AHS IT Change Advisory Board (AHS CAB) implemented.
- Sept 2009 - Project Charter for AHS Integrated Service Management Solution approved.
- Nov 2009 – Service Design framework aligned with Project Management methodology to facilitate the transition from ‘project’ to ‘operation’.
- Feb 2010 - IT Service Management team formed with a provincial mandate and structured to align with ITIL V3 Service Lifecycle approach.
- Feb 2010 – Request for Proposals released to the software vendor community for an AHS Integrated Service Management Solution.
- By May 2010 - "Preferred Vendor" for the Integrated Service Management solution identified and contract negotiations initiated.

Service Desk: In 2009/2010, Service Desk operations started operating in a 'Zonal' mode where former health identity Service Desks are being unified to support a Zone. All provincial operational support knowledge (e.g., Provincial email support) has been uniformly distributed across all Service Desks. Any provincial integrated incident management has also been coordinated. Initiatives were also launched to leverage common call management systems to enable an integrated provincial Service Desk.

Incident Management: Progress was made during the year on the common province-wide AHS Incident Management process and accompanying documentation. This work prepared IT for future planning and design with the "Preferred Vendor" for the Integrated Service Management solution, and for the Spring 2010 launch the IT Major Incident Process, which aims to ensure that major IT service issues are quickly identified and appropriately acted upon.

Problem Management: The development of a common AHS Problem Management process and accompanying documentation also proceeded in 2009/2010. This work will input into future planning and design with the "Preferred Vendor" for the Integrated Service Management solution and ensure alignment of software functionality with ITIL process implementation.

Change Management: In July 2009, the AHS IT Change Advisory Board was inaugurated to ensure the effective coordination and approval of IT changes with touch points provincially. Membership includes representatives from 13 locations who meet weekly via teleconference to review and approve changes. The Board addressed 86 requests in its first 5 months (July through December 200) and 101 requests in its second 5 months of operation (January through May 2010).

Local change management processes will continue to be managed in the former health entities until the Provincial AHS Change Process is finalized (Summer 2010) and implemented within the new Integrated Service Management solution, starting in Winter 2010.

Release Management: At year end, work was also underway on the AHS Release Management process and accompanying documentation in preparation for planning and design with the "Preferred Vendor" for the Integrated Service Management solution, enabling alignment of software functionality with process implementation efforts.

Adherence to data and information protocols data and information flowing into Alberta Netcare repositories as per EHRDSC requirements

identified within provincial operating agreements:

AHS IT requires that every data source provider signs an Information Manager Agreement stipulating that the source provider is responsible for data quality. As part of this requirement, data sources must align with provincial HISCA data submission standards.

Alberta Netcare portal user count:

The total number of unique users who have accessed Alberta Netcare Portal grew by 10,215 (44.2%) from 23,108 at the end of March 2009 to 33,323 at the end of March 2010.

In the 6 month period prior to fiscal year end, 24,227 users accessed Alberta Netcare Portal. This compares to 19,038 in the same period for the previous fiscal year, an increase of 5,189 or 27.3%.

Adherence to adopted Electronic Medical Record/ Electronic Health Record standards

AHS IT ensures that solutions benefit from adopted standards through a number of mechanisms:

- Engagement in working groups for HISCA and SNOMED;
- Evaluation of new developments such as IMO for the physician/user interface to SNOMED
- Assurance that solutions can meet reporting requirements, such as NACRS for ambulatory reporting
- Assurance that vendors subject their solutions to a rigorous assessment. For example, the vendor for the current Edmonton ambulatory solution (Epic) completes conformance testing annually to ensure compliance with CCHIT standards (U.S. Certification Commission for Health Information Technology).

STRATEGIC GOAL 5: Building a strong foundation for public health.

Priority: Emergency Preparedness

A Board approved province-wide emergency response plan for communicable disease emergencies (i.e. pandemic influenza, SARS, smallpox) that is synchronized with provincial emergency response plans.

With the transition from nine former Regions to AHS and the response to Pandemic (H1N1) 2009, a large amount of foundational work was undertaken, however a province wide plan for Communicable Disease has not been complete.

Foundational work that has occurred and will support the end plan include:

- Development of a "Guideline for Outbreak Prevention, Control and Management Plan in Acute Care and Facility Living Sites": http://www.albertahealthservices.ca/files/ns-h1n1-facility-outbreak-prev-cont-mgmt.pdf
- Development and implementation during the pandemic, of a provincial AHS Command / Control network that utilizes the Incident Command System (ICS) as a standardized organization structure
- Development of a governance structure that reflects the relationship between AHW, AHS and AEMA; utilized during the pandemic response; currently under review relative to additional role clarity
- Development and implementation of numerous operational pandemic plans that will be transferable and functional in other Communicable Disease outbreaks. These included:
  - Mass Vaccination Plan
  - Extensive WH/S respirator fit testing program
  - Ethical framework
  - Prioritization of services triggers/triage tools
  - IPC Guidance material relative to visitors, site tours, etc.
  - Assessment Center Plans
  - Emergency Medical Services Plans that allow for activation of Rapid Response Units for assessment and triage
  - Development of plans to prevent and manage outbreaks in Shelters, schools and conjugate settings
  - Acquisition of portable isolation containment tents that have HVAC systems to support positive and negative pressure needs; may be utilized for overcapacity, isolation of highly contagious patient (e.g. smallpox, Ebola, etc.) or as triage area.
  - Involvement in planning of expansions at some sites; resulted in added capacity by pre-positioning second head gas in larger private rooms; also established HVAC controls to enable flexibility in environmental air flow (e.g. Halls positive to rooms)
  - Implementation of a Chemical, Biological, Radiological, Nuclear Program in Calgary Zone; equipment purchased for Edmonton Zone;

Work to occur:

- Review of smallpox and other related plans to identify commonalities
- Meet with AHW to link planning with Ministry, policy and regulations
- Expansion of First Receiver CBRNe Program to all Zones
- Create clarity of roles / responsibilities of PHAC Quarantine Officers, their linkages to AHS, etc.
- Compilation of all plan components into a single response plan. Anticipated date for completion – June 2011.

Other Emergency / Disaster Management Progress in 2009 / 2010:

- Supported the commissioning of the Zone Emergency Operations Centers and the Provincial AHS Emergency Coordination Centre
- In conjunction with AHW, facilitated cross Ministerial pandemic planning activities
- Staffed AHS Pandemic Information Center from July 2009 to October 20, 2009
- Provided support to Zone and Provincial Operations / Coordination centers during H1N1 activation
- Facilitated 43 debrief sessions in aftermath of H1N1; prepared Summary Report with "Actions for Consideration"; providing ongoing follow up on actions taken
- Providing oversight and monitoring of Business Resumption / Recovery activities in the aftermath of H1N1
- Commenced 24/7 on call service for AHS EDM
- Facilitated the reimplementation of the provincial Critical Infrastructure assessments as part of the Solicitor General's
- Provincial Counter Terrorism Plan
- Developed a provincial EDM planning structure
- Developed an Incident Management System Plan for AHS; to be forwarded for approval
- Developed a draft AHS Business Continuity Governance Policy and framework; to be approved at Executive level
- Facilitated and / or participated in response and post incident debriefing for winter storms, Hythe gas well blow out, Boyle Hospital evacuation,
- Conducted large Control Center exercise (Zone and Facility Leadership – Calgary)
- Standardization of plans for Code grey (air exclusion), Code Brown (Hazardous Spill) and Code White (controlled access / lock down).

Priority: Children's Mental Health Three Year Action Plan (2008-2011)

In collaboration with Alberta Health and Wellness and other stakeholders, progress and results achieved toward implementation of the Children's Mental Health Action Plan

Implementation of the Children's Mental Health Plan for Alberta proceeded as planned during 2009/2010, despite some delays related to staff recruitment. With leadership provided by the Provincial Children's Mental Health Working Group, priority actions commenced across the province (rural and urban) using a collaborative approach between health services, schools and community agencies.

- Staffing for 24-hour mental health crisis intervention services in Edmonton, Calgary, Fort McMurray and Brooks.
- Expansion of the community response team with addition of a South Zone Aboriginal Child Life Specialist to work with clients and staff to build capacity.
- Pre-natal, infant and pre-school developmental screening and early intervention to families and young children at risk for developing mental health problems. (i.e. North Zone partnership with Public Health and CASA)
- Opening of eight inpatient beds for children in the Edmonton Zone that support the North Zone and work with Community Geographic Teams and transition services to provide support in the communities of origin.
- Four of the nine new sites selected for the expansion of Mental Health Capacity Building (MHCB) Projects for children, youth and families in schools. Communities include Leduc, Vermillion, Janvier and a continuation of the existing project in High Prairie.
- Safe and Caring Schools Society (Peer Support Model) contracted and recruitment underway for pilots in schools in Lethbridge, Camrose and Alexander First Nation.
- Fiscal year results for performance measure (% of children receiving scheduled mental health treatment with 30 days) available June 30, 2010.

Priority: Framework for a Healthy Alberta

In collaboration with Alberta Health and Wellness and other stakeholders, progress and results achieved toward reaching the 2012 goals of the Framework for a Healthy Alberta

The Health Promotion, Disease and Injury Prevention (HPDIP) Action Plan: 2010–2012 and Beyond is focused on all Albertans within a provincial frame. The intent of the plan is to enhance the health of the population and support Albertans to increase control over their health. Further, this plan provides the direction for investments in health promotion including: fostering and promoting positive social and environmental conditions that mitigate the determinants of health, promoting healthy development, early detection and proactive interventions to prevent disease and injury. Health promotion and disease prevention strategies both reduce and delay entry into the healthcare system and improve quality of life and societal productivity.

HPDIP will accomplish this for Albertans through the following three broad objectives:

1. Increase protective factors within the population
2. Reduce risk factors within the population
3. Increase early detection and minimize downstream intervention in populations

Five priority areas of action for HPDIP include: Social and Physical Environments, Healthy Development, Cancer and Chronic Disease Prevention, Injury Prevention, and Addiction and Mental Health. Three sources - evidence, current programming and stakeholder input - were instrumental in informing the action plan. Based on this information, key performance areas were identified and indicators have been established for some, while others are under development. Each area has a direct correlation to the strategic focus areas of Alberta Health Services (AHS), specifically the goals of quality, access and sustainability. By directly linking the work done in HPDIP to the greater organizational objectives, the HPDIP team will contribute to the performance and success of AHS. The five key areas of action for HPDIP and related key performance areas are outlined below.

Social and Physical Environments
- Health Disparities
- Built Environments
- Social Environments

Addiction and Mental Health
- Resiliency
- Stigma and Discrimination
- Alcohol Consumption

Injury Prevention
- Suicide
- Transportation
- Falls

Cancer and Chronic Disease Prevention
- Healthy Weights
- Tobacco Use
- Screening

Healthy Development
- Birth Outcomes
- Screening and Early Detection
- Children's Oral Health

The Action Plan is ambitious and builds upon the great deal of work that is already underway.

The most gains will be achieved by influencing all sectors (non-health and health) to intensify and harmonize their efforts in both policy and interventions to prevent diseases and conditions that will save needless morbidity and premature mortality. Success will be dependent upon successful nurturing and expansion of the rich network of collaborators across the province in the health, social and non-governmental sectors.

The AHS population health promotion team has the capacity to work closely with partners to realize the commitments outlined in the action plan.

Priority: Blood Borne Pathogens and Sexually Transmitted Infections

In collaboration with Alberta Health and Wellness and other stakeholders, progress and results achieved in implementation of the Blood Borne Pathogens and Sexually Transmitted Infections Action Plan (June 2008)

A joint AHW and AHS Steering Committee has been established to create a provincial strategy to prevent Sexually Transmitted Infections. A number of working committees will be created. Work underway includes:

- A social marketing campaign, including an evaluation component, and
- A Blood Borne Pathogens and Sexually Transmitted Infections Prevention project with a Supervisor and 13 Prevention Coordinators hired for one year to promote sexual health, health education and awareness in youth and adults.

Priority: Aboriginal Health

The Aboriginal Health program and organizational structure has been created within Alberta Health Services. The Director, Aboriginal Health, was appointed in January 2010. Regular meetings have been established between Federal and Provincial governments and Alberta Health Services. Links have been made between internal AHS stakeholders and external First Nations, Metis and other Aboriginal entities and communities. The development of an Aboriginal health plan has commenced.

Priority: Community Health Councils / Health Advisory Councils

Albertans will continue to provide input on local health issues across the province with the establishment of Health Advisory Councils. The 12 Health Advisory Councils replaced 59 Community Health Councils which operated under the former health regions. The new Health Advisory Councils consist of 10 to 15 members, including a Chair and will each represent a different geographical area.

All Health Advisory Council members are appointed by the Alberta Health Services Board. Members include individuals who possess deep connections with diverse communities and knowledge about issues in local areas that can be brought forward during Council meetings. The mandate of the Councils is to provide feedback about what is working well in the healthcare system and areas in need of improvement. The Councils will engage residents and report on local perspectives of healthcare delivery in communities across the province.

The objective of the Health Advisory Councils is to advise Alberta Health Services on healthcare in the best interest of Albertans. Health Advisory Councils will provide meaningful opportunities for public engagement with Alberta Health Services by gathering input and feedback on local health service delivery issues in communities across the province. Council operations are supported through the Alberta Health Services department of Community Engagement. Each Council has assigned to it a Community Engagement Officer to ensure consistency across the Councils and to further act as a bridge to AHS.